Greater Meridian Health Clinic, Inc.

A

Kemper Family Medical Clinic • Shuqualak-Noxubee Health Center • Winston County Family Medical Center • Oktibbeha Family Medical Center • Scooba Family Medical Clinic • West End TJ Harris • Meridian High SBC

Previsit Questionaire - 12 Month

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

If more born than 3 weeks prematurely,

number of weeks early: _____

Child's Gender **Male** ☐ **Female** ☐

Child ID #: _____

Program ID #: _____

Age at Administration (months/days): _____ / _____

If premature, adjusted age (months/days): _____ / _____

Program Name: _____

_____

_____

Form Completed By: _____

Relation to Child: _____

Address: _____

City: _____ ST: ____ Zip Code: _____

Home Telephone: _____

Other Telephone: _____

Email: _____

Names of people assisting with questionaire:

_____

_____

_____

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Family Support	☐ Ways to manage your child's behavior ☐ Finding time for yourself ☐ Parent/family community activities
Establishing Routines	☐ Nap time routines ☐ Bedtime routines ☐ Brushing teeth ☐ Starting family traditions
Feeding Your Child	☐ Using a spoon and cup ☐ Healthy food choices ☐ How many meals or snacks a day ☐ How much should your child eat ☐ Change in appetite and growth ☐ Your child's weight
Finding a Dentist	☐ Your child's first dental checkup ☐ Brushing teeth twice daily ☐ Finger sucking, pacifiers, and bottles
Safety	☐ Home safety indoors and outdoors ☐ Car safety seats ☐ Water safety ☐ Gun safety ☐ Older siblings watching your child ☐ Foods that might cause choking

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: _____

_____

_____

Previsit Questionaire - 12 Month

Questions About Your Child - ***continued***

Hearing	Do you have concerns about how your child hears?	☐ Yes	☐ No	☐ Unsure
	Do you have concerns about how your child speaks?	☐ Yes	☐ No	☐ Unsure
Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure
	Does your child hold objects close when trying to focus?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	☐ Yes	☐ No	☐ Unsure
	Have your child's eyes ever been injured?	☐ Yes	☐ No	☐ Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high rish for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Oral Health	Do you know a dentist to whom you can bring your child?	☐ Yes	☐ No	☐ Unsure
	Does your child's primary water source contain flouride?	☐ Yes	☐ No	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

_____

_____

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other problems: _____

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Child

Do you have specific concerns about your child's developement, learning or behavior? ☐ No ☐ Yes, describe:_____

_____

_____

Check off each of the tasks that your child is able to do:

☐ Bangs toys together	☐ Waves bye-bye	☐ Tries to do what you do
☐ Stands alone	☐ Drinks from a cup	☐ Speaks 1 to 2 words
☐ Babbles	☐ Tries to make the same sounds you do	☐ Looks at things you are looking at
☐ Cries when you leave	☐ Hands you a book to read	☐ Follows simple directions
	☐ Plays peekaboo	

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C

Previsit Questionaire - 2 Years

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

If more born than 3 weeks prematurely,

number of weeks early: _____

Child's Gender **Male** ☐ **Female** ☐

Child ID #: _____

Program ID #: _____

Age at Administration (months/days): _____ / _____

If premature, adjusted age (months/days): _____ / _____

Program Name: _____

_____

_____

Form Completed By: _____

Relation to Child: _____

Address: _____

City: _____ ST: ____ Zip Code: _____

Home Telephone: _____

Other Telephone: _____

Email: _____

Names of people assisting with questionaire:

_____

_____

_____

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Talking Child	☐ How your child talks ☐ Reading together
Your Child's Behavior	☐ Praising your child ☐ Helping your child express feelings ☐ Knowing how to give your child limited choices ☐ Playing with others ☐ Helping your child follow directions ☐ Your child's weight
Toilet Training	☐ Signs your child is ready to potty train ☐ Helping your child potty train
Your Child and TV	☐ How much TV is too much TV ☐ Learning activities besides TV ☐ How to be physically active as a family
Safety	☐ Car safety seats ☐ Bike helmets ☐ Being safe outside ☐ Gun safety

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: _____

_____

_____

Hearing	Do you have concerns about how your child hears?	☐ Yes	☐ No	☐ Unsure
	Do you have concerns about how your child speaks?	☐ Yes	☐ No	☐ Unsure

Previsit Questionaire - 2 Year

Questions About Your Child - *continued*

Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure
	Does your child hold objects close when trying to focus?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	☐ Yes	☐ No	☐ Unsure
	Have your child's eyes ever been injured?	☐ Yes	☐ No	☐ Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high rish for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dl or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Do you ever struggle to put food on the table?	☐ Yes	☐ No	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals or beans?	☐ Yes	☐ No	☐ Unsure
Oral Health	Des your child have a dentist?	☐ Yes	☐ No	☐ Unsure
	Does your child's primary water source contain flouride?	☐ Yes	☐ No	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

_____

_____

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other problems: _____

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Child

Do you have specific concerns about your child's developement, learning or behavior? ☐ No ☐ Yes, describe:_____

_____

Check off each of the tasks that your child is able to do:

☐ Stacks 5 or 6 small blocks	☐ Throws a ball overhand	☐ Turns book pages 1 at a time
☐ Kicks a ball	☐ Names 1 picture such as cat, dog, or ball	☐ Plays pretend
☐ Walks up and down stairs 1 step at the time while holding the wall or railing	☐ Jumps up	☐ When talking, puts 2 words together, like "my book"
☐ Can point to at least 2 pictures that you name when reading a book	☐ Copies things that you do	☐ Plays alongside other children
	☐ Follows 2-step commands	

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E

Previsit Questionaire - 3 Year

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

If more born than 3 weeks prematurely,

number of weeks early: _____

Child's Gender **Male** ☐ **Female** ☐

Child ID #: _____

Program ID #: _____

Age at Administration (months/days): _____ / _____

If premature, adjusted age (months/days): _____ / _____

Program Name: _____

_____

_____

Form Completed By: _____

Relation to Child: _____

Address: _____

City: _____ ST: ____ Zip Code: _____

Home Telephone: _____

Other Telephone: _____

Email: _____

Names of people assisting with questionaire:

_____

_____

_____

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Family Support	☐ Balancing work and family ☐ Giving your child choices ☐ Having time alone with your partner ☐ Being consistent with your child ☐ Showing affection to your child ☐ How to use time-outs ☐ How is your child getting along with siblings ☐ Taking time for yourself ☐ Your child's weight
Reading and Talking With Your Child	☐ How to get your child interested in reading ☐ What to talk about with your child
Playing With Others	☐ Fun games to play with your child ☐ Playing and geting along with other children
Your Active Child	☐ How much TV is too much TV ☐ How to keep your child active
Safety	☐ Car safety seats ☐ Staying safe outside ☐ Gun safety ☐ Crossing the street safely ☐ Preventing falls from windows

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: _____

_____

_____

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Previsit Questionaire - 3 Year

Questions About Your Child - ***continued***

Hearing	Do you have concerns about how your child hears?	☐ Yes	☐ No	☐ Unsure
	Do you have concerns about how your child speaks?	☐ Yes	☐ No	☐ Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high rish for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Anemia	Do you ever struggle to put food on the table?	☐ Yes	☐ No	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals or beans?	☐ Yes	☐ No	☐ Unsure
Oral Health	Does your child have a dentist?	☐ Yes	☐ No	☐ Unsure
	Does your child's primary water source contain flouride?	☐ Yes	☐ No	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

_____

_____

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other problems: _____

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Child

Do you have specific concerns about your child's development, learning or behavior? ☐ No ☐ Yes, describe:_____

_____

Check off each of the tasks that your child is able to do:

☐ Stacks 6 small blocks	☐ Pretend play, such as playing house or school	☐ Toilet trained during the day
☐ Throws a ball overhand	☐ Has a conversation with 2 or 3 sentences together	☐ Draws a person with two body parts
☐ Balances on each foot	☐ Knows the name and use of cu, spoon, ball, and crayon	☐ Can help care for themselves by feeding and dressing
☐ Copies a circle	☐ Usually understandable	☐ Identifies themselves as a boy or girl
☐ Names a friend	☐ Walks up the stairs switching feet	

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G

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Previsit Questionaire - 4 Year

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

If more born than 3 weeks prematurely,

number of weeks early: _____

Child's Gender **Male** ☐ **Female** ☐

Child ID #: _____

Program ID #: _____

Age at Administration (months/days): _____ / _____

If premature, adjusted age (months/days): _____ / _____

Program Name: _____

_____

_____

Form Completed By: _____

Relation to Child: _____

Address: _____

City: _____ ST: ____ Zip Code: _____

Home Telephone: _____

Other Telephone: _____

Email: _____

Names of people assisting with questionaire:

_____

_____

_____

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Getting Ready For School	☐ How your is doing in preschool ☐ How your child does playing with others ☐ If your child is ready for grade school ☐ How is your child speaking ☐ Your child's feelings ☐ Your child's weight
Healthy Habits	☐ How is your child eating ☐ Brushing teeth ☐ How is your child sleeping
TV and Media	☐ How much TV is too much TV ☐ Encouraging your child to be active
Your Community	☐ Fun activities to do outside the home ☐ Educational programs in the community ☐ Getting along with other children and adults ☐ Feeling safe in your home ☐ Playing safely with other children ☐ Answering questions about your child's body
Safety	☐ Car safety seats and booster seats ☐ Being safe outside ☐ Gun safety ☐ Keeping your child safe from sexual abuse

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: _____

_____

_____

Previsit Questionaire - 4 Year

Questions About Your Child - ***continued***

Lead	Does your child have a sibling or playmate who has or had lead poisoning?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high rish for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have a parent or granparent who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking a cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Do you ever struggle to put food on the table?	☐ Yes	☐ No	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals or beans?	☐ Yes	☐ No	☐ Unsure

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other problems: _____

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Child

Do you have specific concerns about your child's development, learning or behavior? ☐ No ☐ Yes, describe:_____

_____

Does your child have any special care needs? ☐ No ☐ Yes, describe:_____

_____

Check off each of the tasks that your child is able to do:

☐ Builds a tower of 8 small blocks	☐ Hops on 1 foot	☐ Knows their name, age, and whether they are a boy or girl
☐ Copies a cross	☐ Draws a person with 3 parts	☐ Plays board or card games
☐ Can balance on each foot	☐ Dresses themselves, including buttons	☐ Other people can understand what they are saying
☐ Names 4 colors	☐ Plays pretend by themselves and with others	☐ Brushes their own teeth

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Previsit Questionaire - 5 Year

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

If more born than 3 weeks prematurely,

number of weeks early: _____

Child's Gender **Male** ☐ **Female** ☐

Child ID #: _____

Program ID #: _____

Age at Administration (months/days): _____ / _____

If premature, adjusted age (months/days): _____ / _____

Program Name: _____

_____

_____

Form Completed By: _____

Relation to Child: _____

Address: _____

City: _____ ST: ____ Zip Code: _____

Home Telephone: _____

Other Telephone: _____

Email: _____

Names of people assisting with questionaire:

_____

_____

_____

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Ready For School	☐ How your is doing in preschool ☐ How your child does playing with others ☐ If your child is ready for grade school ☐ How is your child speaking ☐ Your child's feelings ☐ Your child's weight
Your Child and Family	☐ Family time together ☐ Your child's chores ☐ Your child handling feelings ☐ Your child being angry
Staying Healthy	☐ Your child's weight ☐ Eating fruits ☐ Eating vegetables ☐ Eating whole grains ☐ Getting enough calcium ☐ 1 hour physical activity per day
Healthy Teeth	☐ Regular dentist visits ☐ Brushing teeth twice daily ☐ Flossing daily
Safety	☐ Street safety ☐ Booster seats ☐ Always wearing safety helmets ☐ Swimming safety ☐ Sunscreen ☐ Preventing sexual abuse ☐ Fire escape and fire drill plan ☐ Carbon monozide alarms in your home ☐ Gun safety

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: _____

_____

_____

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Previsit Questionaire - 4 Year

Questions About Your Child - *continued*

Lead	Does your child have a sibling or playmate who has or had lead poisoning?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high rish for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Anemia	Do you ever struggle to put food on the table?	☐ Yes	☐ No	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals or beans?	☐ Yes	☐ No	☐ Unsure

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other problems: _____

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Child

Do you have specific concerns about your child's development, learning or behavior? ☐ No ☐ Yes, describe:_____

_____

Does your child have any special care needs? ☐ No ☐ Yes, describe:_____

_____

Check off each of the tasks that your child is able to do:

☐ Listens well and follows simple instructions	☐ Draws a person with 6 parts	☐ Balances on 1 foot
☐ Can tell a story with full sentences	☐ Copies squares, triangles	☐ Hops, skips, climbs
☐ Counts to 10	☐ Writes some letters and numbers	☐ Ties a knot
☐ Names at least 4 colors		

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Blood Lead Screening and Healthy Home Summary

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

If more born than 3 weeks prematurely,

number of weeks early: _____

Child's Gender **Male** ☐ **Female** ☐

Child ID #: _____

Program ID #: _____

Age at Administration (months/days): _____ / _____

If premature, adjusted age (months/days): _____ / _____

Form Completed By: _____

Relation to Child: _____

Address: _____

City: _____ ST: ____ Zip Code: _____

Home Telephone: _____

Other Telephone: _____

Email: _____

Names of people assisting with questionaire:

_____

_____

_____

Does your child live in or visit a home, daycare, or other building built before 1950?	☐ Yes	☐ No
Does your child spend at least six hours a week at a home, daycare, or other building built before 1978 which has recent, ongoing, or planned remodeling?	☐ Yes	☐ No
Does your child have a family member or friend who has or had an elevated blood lead level?	☐ Yes	☐ No
Does your child frequently come in contact with an adult who works with lead? (*Examples include: construction, welding, painting, radiator repair, metal recycling*)	☐ Yes	☐ No
Have you seen your child mouthing or touching painted surfaces outside or near the home? (*Example: window sills, door frames, keys, electrical cords, jewelry, vinyl[plastic], mini blinds, or bare soil*)	☐ Yes	☐ No
Do you give your child any home or folk rememdies which may contain lead? (*Examples: Greta or Axarcon [Hispanic], Pay-loo-ah [SE Asia], Ayurvedic medicine [India]*)	☐ Yes	☐ No
Does your child drink well water? (*Example: water pumped from an underground well*)	☐ Yes	☐ No
Does your home have a smoke alarm?	☐ Yes	☐ No
Does your home have a carbon monoxide detector?	☐ Yes	☐ No
Are there signs of water leakage in your home? (*Example: mold and mildew*)	☐ Yes	☐ No
Has your child been diagnosed with asthma by a primary care provider?	☐ Yes	☐ No

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L

CONSENT FORM

I understand that necessary and advisable health care services will be provided by qualified health care professionals of Greater Meridian Health Clinic , Inc. and that I am eligible to receive these services.

I understand the following services will be available:

- Physical Exams
- Vision/hearing screening and referrals
- EPSDT for children (unclothed)
- Follow up services as requested by Physician or Dentist
- Routine lab test
- Dental screenings, cleanings, and dental referrals
- Nutrition counseling

Patient First Name: _____ **Patient Last Name**: _____

Name of School: _____ **Grade**: _____

Date of Birth:_____ **Patient Social Security**: _____

Address: _____ Patient Email: _____

Address 2: _____

City: _____ ST: ____ Zip Code: _____ Emergency Contact Name: _____

Home Telephone: _____ Emergency Contact Phone: _____

Other Telephone: _____

Marital Status: Divorced ☐ Married ☐ Single ☐ Widowed ☐ Legally Separated ☐	Sexual Orientation: Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Will not disclose ☐
Gender Identity: Male ☐ Female ☐ Transgender ☐ Will Not Disclose ☐	Employment Status: Employed ☐ Unemployed ☐
Race: African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other ☐ _____	Language: English ☐ Russian ☐ Spanish ☐ Indian ☐ Other ☐ _____

Primary Insurance Company: _____ Member ID #: _____ Insurance Group: _____

Insured's Name: _____ Insured's Date of Birth: _____ Insured's Social Security #: _____

Physician's Name: _____ Dentist's Name: _____

HEALTH HISTORY - (VERY IMPORTANT - PLEASE FILL OUT COMPLETELY) Please check if *patient* has or has had the following:

☐ Chicken Pox	☐ Kidney Problems	☐ Heart Problems	☐ Cleft Lip, Palate	☐ Tuberculosis
☐ Frequent Colds	☐ Anemia	☐ Liver Problems	☐ Tonsilitis	☐ High Blood Pressure
☐ Meningitis	☐ Blood Transfusions	☐ Ear Infections	☐ Respiratory Problems	☐ Hepatitis
☐ Seizures	☐ Eye Problems	☐ Diabetes, Hypoglycemia	☐ Artificial Joints, Bones, Implants	☐ Cancer, Tumors, Chemotherapy
☐ Asthma	☐ Hearing Problems			
☐ Serious Injuries	☐ Speech Problems	☐ Bleeding Disorder	☐ HIV+, AIDS, ARC	☐ Jaw Problems
				☐ Other

Please explain any items checked: _____

_____

Please list regular medications taken: _____

_____

Do you have any allergies to latex, medication(s), or anything else? ☐ No ☐ Yes, Explain: _____

_____

Do you have any dental pain/problems? ☐ No ☐ Yes, Explain: _____

_____

CONSENT FORM - *continued*

FAMILY HEALTH HISTORY - Please use the following abbreviations to identify famly members who have had any of the following illnesses: F = Father **M** = Mother **S** = Sibling (Sister/Brother) **MP** = Mother's Parent **FP** = Father's Parent

___ Heart Disease	___ High Blood Pressure	___ Tuberculosis	___ Cancer	___ Kidney Disease
___ Mental Retardation	___ Stroke	___ Seizures	___ Diabetes	___ Birth Defect
___ Sickle Cell Trait	___ Sickle Cell Disease	___ Asthma	___ Mental Illness	

I give consent for the patient to receive a complete physical examination upon completion of a medical and/or dental history. For the students, I also consent to the exchange of limited health imformation between medical staff and school officials. Other disclosures of a student's health information will be made only under emergency circumstances to protect the health and safety of the patient or other students. This consent form is valid for one year of services via the Greater Meridian Health Clinic Mobile Access to Care Unit.

Patient or Guardian Signature: _____ Date: _____

(Must be signed in order to be seen.)

Greater Meridian Health Clinic, Inc.

Kemper Family Medical Clinic • Shuqualak-Noxubee Health Center • Winston County Family Medical Center • Oktibbeha Family Medical Center • Scooba Family Medical Clinic • West End TJ Harris • Meridian High SBC

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HIPAA ACKNOWLEDGEMENT FORM

By my signature below, I acknowledge that I have received a Notice of Privacy Practices of Protected Health Information from Greater Meridian Health Clinic, Inc.

Patient Name: _____

Account Number: _____

Patient (or Guardian) Signature: _____

Date: _____

Witness Signature: _____

Date: _____

PATIENT CONTACT INFORMATION

I authorize Greater Meridian Health Clinic, Inc. to release my records and discuss my medical condition with the following person(s):

Person's Name: _____ **Relationship**: _____

Person's Name: _____ **Relationship**: _____

Person's Name: _____ **Relationship**: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Greater Meridian Health Clinic, Inc. or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s), it may become subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____