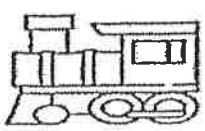

BARES PEDIATRICS

4650 Ambassador Caffery Pkwy
Suite 206
Lafayette LA 70508
337-988-2345

Patient Information:

Name (first, middle, last): _____

Preferred Name: _____

Date of Birth: _____ **Gender:** ____Male ____Female

Race: ____Black/African American ____Hispanic ____White/Caucasian

____Other

Mother's Information:

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email Address:** _____

Phone Number: _____

Employer: _____ **Occupation:** _____

____ **Single** ____ **Married** ____ **Divorced** ____ **Widowed**

Father's Information:

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email Address:** _____

Phone Number: _____

Employer: _____ **Occupation:** _____

____ **Single** ____ **Married** ____ **Divorced** ____ **Widowed**

Sibling's: (Name, Date of Birth, Indicate if they are a patient here)

1._____ D.O.B_____ Patient here: Y/N_____

2._____ D.O.B_____ Patient here: Y/N_____

3._____ D.O.B_____ Patient here: Y/N_____

4._____ D.O.B_____ Patient here: Y/N_____

5._____ D.O.B_____ Patient here: Y/N_____

Emergency Contact: (OTHER THAN PARENT)

Name: _____

Phone number: _____

Relationship: _____

Preferred Pharmacy: _____

Insurance Information:

Primary Insurance Company: _____

Name of Subscriber (person who carries the insurance): _____

Subscriber's Date of Birth_____

Relationship to child_____

Insurance Phone #: _____

ID # or Policy #: _____ Group #: _____

Family and Birth History:

Birth Place: (hospital) _____

Birth Weight: ____ lbs ____ oz Length: _____

Head Circumference: _____

Gestational age: (weeks) _____

Type of Delivery: (vaginal or c-section) _____

If c-section, give reason: _____

_____

Feeding: (Breast or formula/type) _____

Any complications during pregnancy: Yes / No

If yes, please explain: _____

_____

Any complications during delivery: Yes / No

If yes, please explain: _____

_____

Mother's blood type: _____ Father's blood type: _____

Patient's blood type: _____

Current medications: _____

_____

Medication Allergies: _____

Biological Family History:

Have any **IMMEDIATE** family members had the following?

What family member?

CHILD HEARING LOSS Yes / No / Don't know _____

HIGH BLOOD PRESSURE Yes / No / Don't know _____

ASTHMA Yes / No / Don't know _____

HEART DISEASE Yes / No / Don't know _____

HIGH CHOLESTEROL Yes / No / Don't know _____

ANEMIA Yes / No / Don't know _____

BLEEDING DISORDER Yes / No / Don't know _____

CANCER Yes / No / Don't know _____

LIVER DISEASE Yes / No / Don't know _____

KIDNEY DISEASE Yes / No / Don't know _____

DIABETES Yes / No / Don't know _____

EPILEPSY/ CONVULSIONS Yes / No / Don't know _____

OTHER ILLNESSES: _____

_____

BARES PEDIATRICS

CANCELLATION POLICY/NO SHOW POLICY

If an appointment is not canceled at least 24 hours in advance or you are a no-show, you will be charged a $25 fee. This fee will not be covered by your insurance and must be paid before any appointment can be rescheduled.

If a patient is 15 minutes past their scheduled appointment time, we will have to reschedule the appointment.

*MEDICAID Patients: After 3 no-show appointments, your family will be released from our practice and you will need to find a new provider and medical home.

_____ _____

Parent/Guardian Signature Date

_____

Patient Name/Names

CONSENT FOR USE AND DISCLOSURE

Jude Bares, MD
Pediatric & Adolescent Medicine

By signing this form, you consent to our use and disclosure of Protected Health information about you for treatment, payment and health care operations. You have a right to revoke this consent, in writing, except where we have already made disclosures in compliance on you prior consent.

1. Jude Bares, MD will use and disclose you P.H.I. as stated in the Notice of Privacy Practices. We will not use or disclose you P.H.I. for any purpose not mentioned in the Notice of Privacy Practices without your specific written authorization. Any specific authorization you provide may be revoked at any time by writing to the Compliance Officer at Jude Bares, MD.

2. If any change occurs in the Notice of Privacy Practices for Jude Bares, MD, a copy of this change will be available upon request.

3. If you think your privacy rights have been violated, submit a written complaint to the Compliance Officer noted below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with this address. We will not retaliate in any way if you choose to file a complaint.

Print Patient Name _____

Signature _____

Date _____

If patient is a Minor, Print and Sign Parent or Legal Guardian Name

Print _____

Signature _____

Submit questions and/or Complaints in writing to:

ELISE BROUSSARD
PRIVACY OFFICER
JUDE BARES, MD
PEDIATRIC & ADOLESCENT MEDICINE
P.O. BOX 81885
LAFAYETTE, LA 70598