



## OFFICE VISIT CHECKLIST

- Please arrive 20 minutes early to your appointment for check in.**
- Bring your insurance cards to your appointment, everytime.
- It is your responsibility to understand your insurance coverage.
  - Which physicians are covered in your plan?
  - What are your co-pay amounts for office visits?
    - You may pay your co-pay at the time of your visit.
    - Cash, check or credit card is accepted.
- Questions about your insurance?
  - Call your employer's Human Resource Department or the telephone number on your insurance card.
  - Every health care plan varies based on your employer.
- Review your pharmacy benefits.
  - Do you need a 30 day or 90 day prescription?
  - Should you have generic versus brand name medications.
  - What pharmacies can you use?
  - Is the medication on the formulary?
  - Do you need prior authorization?

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Child's Birthdate: \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_ Name of School &amp; Grade \_\_\_\_\_

 Address: \_\_\_\_\_  
 (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Race: White • Asian • Native Hawaiian • Other Pacific Islander • African American • American Indian • Alaska Native • Decline

Language: English • Spanish • Hmong • Other • Decline      Ethnicity: Not Hispanic/Latino • Hispanic/Latino • Decline

### Parent Information

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

 Are Parents:  Married  Divorced  Separated

Who else lives in the child's home? \_\_\_\_\_

Please list the names and relationships of anyone else involved in the child's care: \_\_\_\_\_

### Family History

Names and birthdates of siblings: \_\_\_\_\_

Family Health History: Does anyone in your family suffer from?

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Alcoholism/Drug abuse				High Blood Pressure			
Allergies				High Cholesterol			
Asthma/Hay fever/Eczema				Inherited/Genetic Disease			
Birth Defects				Kidney Disease			
Bleeding/Clotting Issues				Psychiatric Disorders			
Cancer				Seizures			
Depression				Stroke/Heart Disease			
Diabetes				Thyroid Disorder			

## Newborn/Infant History

(Please fill out if child is less than 5 years of age)

Birth weight: \_\_\_\_\_ Method of Delivery:  Vaginal  C-Section  Forceps/Vacuum

Length of pregnancy: \_\_\_\_\_ weeks Feeding:  Breast  Bottle  Both

Problems during pregnancy or delivery: \_\_\_\_\_

While in the hospital, did the child have any of the following?

Condition	Y	N	Condition	Y	N
Jaundice			Infection		
Poor Feeding			Breathing Concerns		

Other concerns during hospital stay:

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Did mother and child leave the hospital together? If no, please explain: \_\_\_\_\_

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How many hours per night does your child sleep? \_\_\_\_\_ Naps? (Number & Length) \_\_\_\_\_

Does your child have any sleep problems? If yes, explain: \_\_\_\_\_

Has your child been immunized?  Yes  No If yes, in WI?  Yes  No Other state? \_\_\_\_\_

Has your child been seen by a dentist? Yes  No  If yes, date of last visit \_\_\_\_\_

Does anyone in the home smoke? Yes  No  Has your child been exposed to lead? Yes  No

## Health History

Please list all current medications and supplements:

MEDICATION NAME	DOSE	FREQUENCY

Please list any allergies and reactions:

ALLERGY	REACTION
Non-Drug:	
Drug:	
Food/Seafood:	

Did this child have, or does this child now have any of the following?

Condition	Y	N	Date	Condition	Y	N	Date
Frequent Colds/Infections				Chronic Cough			
Easy bruising or bleeding				Wheezing or Asthma			
Loss of consciousness				Poor appetite			
Head Injury				Weight loss			
Seizure or convulsion				Heart murmur			
Frequent headaches				Bloody stool			
Eye problems				Blood in urine			
Recurrent ear infections				Swollen joints			
Hearing problems				Frequent falling			
Constipation				Dental cavities			
Chronic vomiting or diarrhea				Skin problems			
Frequent stomach aches				Ingestion of poison			
Bladder/Kidney problem				Chicken pox			
Meningitis				Whooping cough			

Please list any previous hospitalizations or surgeries:

PREVIOUS HOSPITALIZATIONS	PREVIOUS SURGERIES

Concerns about your child:  Alcohol use  Tobacco use  Sexual Activity  Aggressive behavior

Is violence at home a concern?  Yes  No If yes, explain: \_\_\_\_\_

Girls only: Age of first menstrual period? \_\_\_\_\_

Current grade? \_\_\_\_\_ Name of school? \_\_\_\_\_

Sports/exercise. Type? \_\_\_\_\_ How often/minutes per day? \_\_\_\_\_

How many hours per day does your child do the following?

Watch TV \_\_\_\_\_ Computer \_\_\_\_\_ Video Games \_\_\_\_\_

Any other major illness? If yes, explain: \_\_\_\_\_

*Thank you for choosing our office, we look forward to caring for your child.*



## AUTHORIZATION FOR TREATMENT of a MINOR

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize \_\_\_\_\_ to bring the above named  
(Name/Relationship to Patient)  
individual to an OakLeaf Clinics, Inc provider for care.

This authorization is in effect until: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
(Please Print)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**PATIENT:**

Patient Name/Previous Name(s)

Date of Birth

Street Address

City, State, Zip Code

**AUTHORIZES FROM:****RELEASE OF PROTECTED INFORMATION TO:**

Name of Health Care Provider/Plan/Other

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City, State, Zip Code

City, State, Zip, Code

For the following dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**INFORMATION TO BE RELEASED:**

Medical History, Examination, Reports       Surgical Reports       Immunizations  
 Treatment or Tests       Hospital Records/Reports       Radiology Reports       Laboratory Reports  
 Consultations       Other \_\_\_\_\_

In compliance with Wisconsin Statutes, to release privileged information; Please release records pertaining to:

Mental Health       Developmental Disabilities       Alcohol & Other Drug Abuse  
 HIV (AIDS)       Sexually Transmitted Disease Results       Clinic Therapy (counseling) Notes  
 Mental Health Admission/Discharge Summary       Mental Health Hospital Assessments/Notes

**PURPOSE OF DISCLOSURE:**

Further Medical Treatment       Legal Investigation/Action       Personal  
 Insurance Eligibility/Benefits       Changing Physicians  
 Other \_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

*Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Oakleaf Clinic, SC. Right to Receive Copy of this Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of the form. Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Oakleaf Clinics, SC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that a person(s) and/or organization(s) listed above have already made in reference to this authorization.*

***Disclosure notice to recipient of mental health, alcohol and/or drug treatment records:***

*This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.*

**EXPIRATION DATE:** This authorization is good until the following date(s) \_\_\_\_\_ or for one year from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

**Note:** A patient (18 years or older) must authorizes the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

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*Signature of Patient or Legal Representative**Date*

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*Relationship (if not patient)*

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*Witness*

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*Date*