HALEYVILLE PEDIATRICS

42030 HIGHWAY 195, Suite E Haleyville, AL 35565
Phone: 205-485-7288 * Fax: 205-485-7290
A DIVISION OF Lakeland community Hospital

Dear Parent/Guardian,

I am thrilled that you have decided to let me help you care for your child. All the time I have spent training to become a pediatrician has been to care for families like yours. If we have never met before, I cannot wait to learn more about your child. If we know each other, I look forward to seeing you again and caring for your child. Regardless of how you got to me, I am honored that you chose me as your pediatrician.

My goal is for us to be a team in caring for your child. Parents, guardians, and caregivers know their children best, and I think your input is essential for me to do my job. I want our time together to be as effective and efficient as possible. To help me, I ask that you complete the registration forms to the best of your ability. It may seem like a lot of paperwork but I use those forms to learn about your child before the appointment so I can be well prepared before meeting with you. Please return these forms to our clinic by mailing them or bringing them to clinic as soon as possible.

Each age and developmental stage is different as children grow. You will notice that our visits may change as your child ages. By 13 years old, I will ask to have a few minutes alone with your child at the end of our visit. This teaches them to interact with a healthcare provider, gain communication skills, and learn to be independent in regard to their medical care. You will always be involved in the care of your child but I also value this kind of interaction with my adolescent patients. I appreciate your understanding and cooperation.

I look forward to caring for your child and helping them grow!

Sincerely,

Dr. Brooke

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Patient Information:

Patient Full Name: _____Preferred Name: _____

Date of Birth: _____ SSN: _____ Age: ____ Male or Female: ___ Race: _____

Address:

_____

Street Apt #

_____

City State Zip

Phone Number(s): _____

Guarantor Information:

Parent/Guardian Name: _____ Guarantor Date of Birth: _____

Relationship to Child: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell phone: _____ Work phone: _____

Email Address (to be used for patient portal): _____

Can we contact you electronically via our secure portal regarding your child's medical care? Yes or No

How do you prefer to be contacted? (please circle): Email Text Call

Insurance Information:

Name of Insurance Co: _____Policy Number: _____ Group Number: _____

Policy Holder Name:_____ Policy Holder DOB: _____

Secondary Insurance Co: _____ Name on Policy: _____

Policy Holder Name:_____ Policy Holder DOB: _____

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Pregnancy and Birth History:

Illness or problems during pregnancy/birth: _____
Vaginal or cesarean (C-Section) birth: _____ If C-Section, why? _____
Gestational age (how many weeks/months pregnant when baby was born?): _____
Problems after birth: _____
Birth weight: _____

Development:

Concerns regarding development: _____
Concerns regarding vision or hearing: _____
Concerns regarding school performance: _____

Medical History:

Current medical problems/disorders: _____
Medication allergies (date and type of reaction): _____
Food Allergies (date and type of reaction): _____
Current Medication (including doses): _____

Social History:

Childcare (school, daycare, etc.:) _____
Name of school/daycare: _____ Current grade in school: _____
Who lives at home with child? Provide name, age, and relationship to child.

_____
_____
_____

Family History:

List disorder that run in the family (especially genetic, congenital, or childhood disorders).

_____
_____
_____

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I give permission to the following adults to see medical care for my child and receive any lab and test results.

Name: _____ Phone number: _____ Relation: _____

Name: _____ Phone number: _____ Relation: _____

Name: _____ Phone number: _____ Relation: _____

Parent/Guardian Signature: _____ Date: _____

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Policies for Haleyville Pediatrics

Forms: Please allow us up to 5 business days to complete forms such as blue slips, lab results, daycare forms, school med forms, personal letters, etc. If you know you will need a form let us know as soon as possible to allow us enough time to get those ready for you. As soon as the form is completed and signed then our office will call and notify you.

Same day sick appointments: We understand children often become sick unexpectedly, however we do ask that you call the clinic to schedule an appointment before walking in the clinic. This will help us keep our commitments to our scheduled patients while also caring for your sick child.

After hours: If your child needs care after regular hours or when we are closed, please call our main office number (205-485-7288) and your call will be forwarded to our answering service. If the operator determines you need further instruction regarding your child's health, your message will be sent to after-hours nurses who will return your call. We do not refill medications or fulfill requests for forms or immunization records outside regular business hours.

Mask/caregiver policy: Everyone entering clinic is required to wear a mask or face covering, and it should be worn the entirety of the visit. We are limiting visitors to clinic and ___ caregivers are currently allowed. If possible, please avoid bringing extra people with you.

No show policy: If you are unable to keep a scheduled appointment, please call our office during business hours to reschedule or cancel to avoid getting a 'no show.' We understand schedules change but ask you call to update us before the scheduled appointment. After 3 no show visits without warning, you will be subject to being dismissed from clinic.

Vaccine Policy: At Haleyville Pediatrics, we follow the Center for Disease Control and Prevention (CDC) and American Academy of Pediatrics (AAP) recommendations for vaccinations. Vaccination is one of the best ways to protect your child from many harmful diseases. The recommended vaccines and vaccination schedule are the results of many years of scientific research. Refusing, delaying, or spreading out vaccines goes against expert recommendations and can put your child at risk for serious illness and even death. Because we are committed to protecting the health of your child, we require all of our patients to receive vaccines on the recommended schedule. If you have questions or concerns regarding the vaccines or vaccine schedule, please call to discuss this with Dr. Goar. If you should refuse to vaccinate your child, we will ask that you find another healthcare provider.

By signing this form, I understand that my child will receive vaccinations at the schedule recommended by the CDC and AAP.

Parent/Guardian signature: _____ Date: _____