Oklahoma Children's Hospital

OU Health

Patient Demographic Information **School:** _____

Patient Name: _____ Soc. Sec. No.: _____ Gender: M F
First Middle Last

Date of Birth: _____

Address: _____
City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Care Provider: _____ Phone No.: _____

Guardian Information: Relationship to Patient _____

Guardian's Name: _____ Soc. Sec. #: _____ Date of Birth: _____
First Middle Initial Last

Address: _____ Phone: _____
City State Zip Code Email: _____

List Additional Emergency Contacts (Other Parent/Guardian)

Contact #1: _____
First Middle Last

Home Phone No.: _____ Work Phone No.: _____ Relationship to patient: _____

Contact #2: _____
First Middle Last

Home Phone No.: _____ Work Phone No. _____ Relationship to patient: _____

Insurance Information Primary and Secondary

1st Insurance Co. Name: _____ Policy No.: _____ Group No.: _____

Policy Holder Name: _____ Date of Birth: _____ Sex: _____

Policy Holder Employer: _____ Relationship to patient: _____

2nd Insurance Co. Name: _____ Policy No.: _____ Group No.: _____

Policy Holder Name: _____ Date of Birth: _____ Sex: _____

Policy Holder Employer: _____ Relationship to patient: _____

Statement of Financial Responsibility and Assignment of Benefits

I understand that my insurance will be billed for services rendered during school telehealth visits in which my student participates however, if I do not have insurance there will be no our of pocket charge to me for school telehealth services for my student.

Date: _____ **Patient/Guardian Signature:** _____

Complete this form before seeing the doctor

Patient Name:_____ Parent/Guardian:_____

Address:_____ City:_____

State:_____ Zip Code:_____

Home telephone:_____ Cell Telephone:_____

Employer:_____ Emp Address:_____ Tel:_____

TUBERCULOSIS SKIN TEST: Has your child been tested for Tuberculosis? If yes list.

_____

ALLERGIES: Does your child have any allergies or reactions to any medicines, shots, foods, or bee stings? If yes, please list.

_____

FAMILY HISTORY:	Name	Age	Birth Date	Health Status	Live with child
Child's Father					
Child's Mother					
Child's brothers					
Child's Sisters					

Does anyone else live in your house? Who? _____

CIRCLE ANY OF THE FOLLOWING THAT YOUR CHILD'S PARENTS, BROTHERS, SISTERS, GRANDPARENTS, AUNTS, UNCLES, OR FIRST COUSINS HAVE HAD:

Alcohol or drug problems
Allergies (hay fever, asthma, eczema)
Anemia (low blood)
Sickle cell disease or trait
Birth defects
Cancer or tumors
Convulsions
Deafness in childhood/young adulthood
Death while still a baby or child
Diabetes (sugar)
Heart Disease/Stroke (before age 60)
High blood pressure
High cholesterol or triglycerides
Kidney trouble
Mental illness
Overweight
Rheumatic Fever
Tuberculosis
Speech difficulties
Learning difficulties In school

Other:

In child's house
Cigarette smoking
Drug problems
Alcohol problems

OVER →

YOUR PREGNANCY AND THE BIRTH OF YOUR CHILD:

What is the name of the hospital where your child was born? _____

How much did your child weight at birth? _____

At how many months of pregnancy did you start seeing a doctor regularly? _____

Was your baby born more than two weeks early or late? _____

Did you have any difficulty with labor or delivery? If yes, please explain:_____

_____

Did the baby come out by itself? _____ by using forceps? _____ Caesarean _____

Did your baby have any of the following? If yes, please circle:

yellow jaundice poor feeding/eating other

YOUR CHILD'S BEHAVIOR AND LEARNING:

Has your child ever had difficulties at school, such as poor grades, in special classes? _____

_____

Has she/he had to repeat a year? _____

Compared to other children you know, has your child been: (please circle)

1) slow to learn average easier
2) hard to raise average easier

Does your child have, or has your child had, any special behavior or emotional difficulties? If yes, please describe, as best as you can. _____

_____

YOUR CHILD'S MEDICAL HISTORY:

What is the name of the doctor/clinic that has been taking care of your child? _____

Approximately when was your child's last checkup? _____

Has your child been hospitalized or had an operation? If so, where, when, and why. _____

_____

Has your child had any serious illnesses , accidents or injuries? If yes, please describe:_____

_____

Please circle any of the following that your child has had:

Regular/10 day measles German/3 day measles mumps chicken pox

Is your child seeing any other doctor? If yes, please give his/her name and address:_____

_____

Parent's Signature:_____ Date:_____

General Consent for Treatment and Acknolwedgement

Consent for Care

General Consent: I consent for the Patient, which may be defined as my child or a child for whom I have legal responsibility, to receive a medical evaluation for medical care and treatments as an outpatient. Care and treatment may be provided by physicians, nurses, and other health care providers and employees. Care and treatment may include evaluation and routine medical, nursing, and other patient care, therapies and procedures. I agree that photos or video of the Patient may be taken in connection with such treatment and for operational, quality improvement, research, and education purposes. I understand that OU Health is a teaching institution and agree that fellows, residents, trainees, students and other approved individuals may observe and participate in the Patient's care and treatment under appropriate supervision. I understand that I have a right to withhold or withdraw my consent to the use of Trainees or Shadowers in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

I voluntarily consent to treatment involving the use of electronic communications ("Telehealth") to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and or education purposes. I consent to forwarding my information to a third party as needed to receive Telehealth services and I understand that existing confidentiality protections apply. I acknowledge that while Telehealth can be used to provide improved access to care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission or equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

Independent Physicians / Dentists / Providers: Treating physicians are not employees of the District. There may also be advanced practice nurses, physician assistants and other health care providers who treat Patients.

Telemedicine / Virtual Visit Care: I agree that care may include evaluation, diagnosis, consultation on, and treatment of the Patient's medical or health condition using advanced telecommunications technology ("Telehealth Services"; may also be referred to as "Virtual Visit Care"). I understand that Telehealth Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via telehealth. Telehealth providers (i) may be in a location other than where the Patient is located, (ii) will examine the Patient face-to-face via a remote presence but will not perform a "hands-on" physical examination, and (iii) must rely on information provided by the Patient and any on-site health care provider(s). The on-site provider is not an employee of OUH but is employed by the school system. OUH takes no liability or responsibility for their actions or performance of the on-site provider in assistance in the telehealth evaluation. Telehealth Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data, or distortions of images or other information from electronic transmissions. I acknowledge that and telehealth providers cannot be held liable for advice, recommendations and / or decisions based on factors not within their control, such as incomplete or inaccurate data provided by the Patient / others or distortions of diagnostic images or specimens that may result from electronic transmission.

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If telehealth providers determine that Telehealth Services do not adequately address the Patient's medical needs, the Patient will be referred for on-site medical evaluation. If the Patient's condition is urgent / emergent, or if the telehealth session is interrupted due to a technological or equipment failure, I agree the Patient will obtain follow up care and treatment if recommended and as needed.

I understand precautions are taken to protect the confidentiality of the Patient's medical information from unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering. The telehealth platform, being used, is a HIPAA compliant video platform.

Telehealth services to be provided include but are not limited to diagnosis, care, and treatment of: asthma, flu, headaches, sore throat, allergies, earaches, pink eye, cough, fever, rashes, cold, head lice, and skin irritations.

Medications / Treatments: Certain drugs and treatments recommended for the Patient by the Treating physician may be prescribed for treatment of the medical condition being evaluated. The Patient is responsible for obtaining the recommended medication. OUH will not provide medication for Patients.

Prescriptions: I consent to OUH accessing prescription databases to review my prior and ongoing prescription history. I may revoke this consent by notifying OUH in writing. If I do not provide consent or if I revoke this consent, I may be terminated as an OUH patient.

No Guarantee: I acknowledge that no guarantees or warranties have been made as to treatment or services provided

Patient Rights: If the Patient is receiving care by an OUH provider, I have received or been offered information regarding the Patient Rights and Responsibilities. This information tells me how to register a complaint or grievance that I might have relating to the Patient's care by the provider.

Use of My Telephone Number: By providing a telephone number to OUH, I consent to calls, texts, SMS messages, artificial voice and prerecorded messages, or other communications of any kind whatsoever placed or sent to me at this number or any obtained by skip tracing by OUH and its contractors, agents, collection agencies and billing services (hereafter "Authorized Entities") at that number or on a device connected to or associated with that number, including calls, texts, SMS messages, artificial voice and prerecorded messages, or other communications placed or sent with an automatic telephone dialing system, auto-dialer, or predictive dialer. I acknowledge I am not obligated to provide this consent and can revoke my consent at any time.

Use of My E-Mail Address: By providing my e-mail address, I authorize the Authorized Entities to send communications to me at the e-mail address provided. I will not provide an email address that is shared, furnished by an employer, or otherwise capable of being accessed by third-parties. I further affirm that I will view electronic communications from the Authorized Entities only in my state of current residence. I acknowledge that providing a telephone number and/or email address is not a condition to/of receiving healthcare services. I further acknowledge the inherent limitations of electronic communication that I initiate or receive, including possible breach of privacy or confidentiality, difficulty in validating the identity of the parties, and possible delays in response.

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Appointment/Refill Reminders: OUH providers want to assure that they effectively communicate with their patients. I have been advised that OUH and OUHP clinics may provide appointment and refill reminders via mail, secure email or patient portal, text, and automated or live telephone messages. I understand that text messages may not be encrypted, so it's possible for them to be viewed by unauthorized individuals.

Education, Feedback, Events, Communications: OUH and OUHP may send me health-related educational materials; patient experience surveys; requests for completion of my medical, social, and family history information to facilitate care; notices about special events for patients and family members such as camps and classes; and recognition of special milestones. I understand that these types of communications may be made by phone, secure email, mail, patient portal, and text messaging. Text messages may not be encrypted, so it's possible for them to be viewed by unauthorized individuals.

Leaving Messages: I understand there are times when OU Health may not be able to reach me. OUH may leave a message that includes information about my health.

Duration of Consent: I understand and agree this Consent for Care and Treatment is valid for services provided for the present visit and future visits for one year unless I revoke the consent prior to that time.

I have read and understand the information in this General Consent for Treatment and Acknowledgements form.

Signature of Patient / Legally Authorized Representative	*Date*
Printed Name of Patient / Legally Authorized Representative	*Relationship to Patient*
Signature of Witness / Interpreter	*Date*