Eau Claire:

3802 W Oakwood Mall Drive * Telephone 715.839.9280 * Fax 715.839.9348

Chippewa Falls:

855 Lakeland Drive * Telephone 715.839.9280 * Fax 715.726.2087

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?

Pediatric Health History *age 12 and under*

Child's Name: _____Today's Date: _____

Child's Birthdate: _____ Female Male Name of School & 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:

_____

_____

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

_____

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, SC 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:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

RELEASE OF PROTECTED INFORMATION TO:

OakLeaf Clinics - ECMC
Phone: 715-839-9280
Fax: 715-552-3791 for Eau Claire office
Fax: 715-720-0747 for Chippewa Falls

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 CRF 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.

_____ _____

Signature of Patient or Legal Representative *Date*

_____

Relationship (if not patient)

_____ _____

Witness *Date*