PEDIATRIC NEW PATIENT PACKET – FOOT & ANKLE
(Age 12 and under)

Eau Claire	Chippewa Falls	Turtle Lake
OakLeaf Clinics - Pine Grove Family Medicine (Stein) 3221 Stein Blvd., Suite 4 Eau Claire, WI 54701 (P) 715.834.2788 (F) 715.834.2845	HSHS St. Joseph's Hospital Specialty Clinic (1st floor) 2661 Co Hwy I Chippewa Falls, WI 54729 (P) 715.834.2788 (F) 715.834.2845	Cumberland Healthcare Turtle Lake Center 632 US Highway 8 Turtle Lake, WI 54889 (P) 715.986.2022 (F) 715.986.2236

REMINDERS

- ☐ Please arrive 15 minutes early to your appointment for check in.
- ☐ Bring this new patient paperwork packet with you.

  If you have been seen by an OakLeaf Clinics provider within the past 12 months and have not had any significant changes in your health, you may skip pages 4 and 5.
- ☐ Bring your insurance card to your appointment.
- ☐ Questions about your insurance?
  - Call your employer's Human Resource Department or the phone number listed on your insurance card.
  - It is your responsibility to understand your insurance coverage as every health care plan varies based on your employer.

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

OakLeaf CLINICS
FOOT & ANKLE

PEDIATRIC INFORMATION (age 12 and under)

Child's name: _____ Today's Date: _____

Child's birthdate: _____ ☐Male ☐Female Name of school and grade: _____

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

Emergency Contact Name: _____ Phone Number: _____

Relationship to child: _____

Race: ☐White ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐African American ☐American Indian ☐Alaska Native Language: ☐English ☐Spanish ☐Hmong ☐Other: _____

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino

Primary Care Provider: _____

How did you hear about OakLeaf Clinics Foot and Ankle? _____

Preferred Pharmacy (include location): _____

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 home? _____

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

_____

Insurance Information: *Required, unless you are self-pay*

Insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ Employer: _____ Work Phone: _____

Relationship to Patient: _____ Birthdate: _____ SSN: _____

What foot or ankle concerns would you like to be addressed at your child's appointment? _____

_____

When did this condition begin? _____ Was it related to an injury? ☐Yes ☐No

If so, what type of injury? _____

What bothers your child most about their foot or ankle? ☐Pain ☐Swelling ☐Instability ☐Deformity

What is your child's average pain due to this foot and ankle condition?

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

No pain *Worst pain*

What activities make your child's symptoms worse?

☐Walking ☐Running ☐Sports ☐Certain shoes ☐Getting up from seated position

Does your child participate in sports or outdoor activities? _____

Which of the following treatments have you tried?

☐Anti-inflammatory medication (start date/frequency): _____

☐Physical therapy (start date/frequency): _____

☐Steroid injection (date of injection): _____

☐Shoe inserts or orthotics ☐Bracing ☐Surgery: _____

Prior diagnostic studies related to foot or ankle (X-rays, MRI, CT, EMG, etc.):

_____

_____

List all previous foot or ankle surgeries (include year of surgery, starting with most recent):

_____

_____

Anything else you would like your provider to know about your child:

_____

_____

OakLeaf CLINICS
FOOT & ANKLE

FAMILY HISTORY
Names and birthdates of siblings: _____

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/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	Yes	No	Condition	Yes	No	Other concerns during hospital stay:
Jaundice			Infection			
Poor feeding			Breathing concerns			

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

How many hours per night does your child sleep? _____ Naps? (number and length) _____

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

Has your child been immunized? ☐Yes ☐No If yes, in Wisconsin? ☐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

MEDICATIONS: *Include all current medications and supplements*

Medication name	Dose	Frequency

OakLeaf CLINICS
FOOT & ANKLE

ALLERGIES:

Type	Allergies	Reaction
Non-drug		
Drug		
Food/seafood		

PAST MEDICAL HISTORY

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

Condition	Yes	No	Date	Condition	Yes	No	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/diarrhea				Skin problems			
Frequent stomach aches				Ingestion of poison			
Bladder/kidney problem				Chicken pox			
Meningitis				Whooping cough			

PREVIOUS HOSPITALIZATIONS: PREVIOUS SURGERIES:

Year	Reason for hospitalization	Year	Type of surgery

Concerns about your child: ☐Alcohol use ☐Tobacco use ☐Sexual activity ☐Aggressive behavior

Is violence at home a concern? ☐Yes ☐No If yes, please explain: _____

Girls only: Age of first menstrual period: _____

Type of sports/exercise: _____ How often/minutes per day? _____

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

Watch TV: _____ Computer: _____ Video games: _____

Any other major illnesses? If yes, please explain: _____

AUTHORIZATION FOR TREATMENT OF A MINOR

Patient name: _____ Date of birth: ___/___/___

I herby authorize _____ to bring the above named
(Name and relationship to patient)

Individual to 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 – Foot & Ankle

Phone: 715-834-2788
Fax: 715-834-2845

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 and other drug abuse

___ HIV (AIDS) ___ Sexually transmitted disease results ___ Clinical 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 authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I herby 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*