Welcome to Carevide

Carevide Locations

Family Medicine

Carevide Bonham
920 N Center St
Bonham, Texas 75418
903.583.6155

Carevide Cooper
91 W Side Square
Cooper, Texas 75432
903.395.0586

Carevide Farmersville
111 N Johnson St
Farmersville, Texas 75442
972.782.6131

Carevide Greenville
4311 Wesley St
Greenville, Texas 75401
903.455.5958

Carevide Kaufman
101 N Houston St
Kaufman, Texas 75142
972.932.7001

Dental

Carevide Dental
3600 Caddo St
Greenville, Texas 75401
903.454.6965

Pediatrics

Carevide Pediatrics
3005 Joe Ramsey Blvd E, Suite A
Greenville, Texas 75401
903.455.4458

Women's Health

Carevide Women's Center
4311 Wesley St, Suite B
Greenville, Texas 75401
903.455.5010

What to Bring to Your Appointment

Please bring the following along with your completed patient packet:

The following will be needed for all household members (if applicable):

- ☐ **Photo Identification** (Driver's License, School, Military, Identification Card, etc.)
- ☐ **Proof of Insurance** (Insurance Card); if applicable
- ☐ **Current medications**

Sliding Fee Discount Requirements:

For all uninsured patients or patients with private insurance that qualify for our sliding fee discount for charges applied to the deductible or non-covered charges, the follow is required:

- ☐ **Three (3) Proof of Income statements for all household members dated within the last 60 days.**
- ☐ **Household members include** spouse, common-law spouse, or live-in boyfriend/girlfriend.
- ☐ **Proof of income may include** check stubs dated within the last 60 days, letter from employer on letterhead, social security award letter, most current tax return (required if you are a business owner), child support, unemployment, and/or a letter of support accompanied with a copy of the supporter's ID and contact information.

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

Carevide

Thank you for choosing Carevide for your health care needs. We know you have a choice in your healthcare provider, but in choosing us, please know that we are committed to being available for you, knowing you and your health history, helping you understand your care and assisting you to coordinate your health care. Carevide offers a range of care including family practice, pediatric care, women's health services, behavioral health and dental services.

As a recognized Patient Centered Medical Home, we are focusing on strengthening the relationship between the patient and the provider by replacing short-term episodic care with long-term relationships and whole-person care. Within a Patient Centered Medical Home, patients are active participants in their care and the primary care provider serves as the "home", where patients go for the majority of their care.

As your Medical Home we will:

- Learn about you, your family, life situation, and health goals
- Coordinate your care with specialists as your health needs change
- Be available to you after hours for your urgent needs, through our on call physicians, which may be accessed by calling the office phone number at any time; during or after office hours
- Communicate clearly with you so you understand your condition(s) and all of your options
- Listen to your questions and feelings
- Help you make the best decisions for your care
- Offer health education
- Provide evidence-based care by integrating clinical expertise with current best practice recommendations, by planning your care according to need and using point-of care reminders based on current guidelines
- Support for self-management
- Provide assistance in obtaining health records from current and/or previous providers

We also encourage you as the patient to be in charge of your own health by participating in your care and communicating openly with your care team.

We trust you, as our patient, to:

- Know that you are a full partner with us in your care
- Provide a complete medical history to your care team
- Come to each visit with any updates on medications, dietary supplements, or remedies you are using, and questions you may have
- Let us know when you see other health care providers or have a visit to the Emergency Room so we can help coordinate the best care for you
- Keep scheduled appointments or call to reschedule or cancel as early as possible
- Understand your health condition(s): ask questions about your care and tell us when you don't understand something
- Contact us after hours if your issue cannot wait until the next work day
- Give us your feedback to help us improve our care for you

Carevide now offers access to a Patient Portal where you, the patient, may contact the center's staff members through direct messaging with any questions, request appointments, check diagnostic and lab test results, view your medication list as well as request your prescription refills.

We thank you again for choosing us as your provider of choice.

Sincerely,
Carevide

Registration Form

PLEASE PRINT

Today's Date: / /

Primary Care Provider (PCP): *or check if establishing today* ☐	Primary Dental Provider: *or check if needed* ☐	If Applicable, Women's Health Provider:

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Name:	Age:	Date of Birth: / /	Sex at Birth: ☐ M ☐ F

Is this the Patient's Legal Name? ☐ Yes ☐ No If No, What is Patient's Legal/Former Name:

Street Address:	City / State / Zip:	P.O. Box:

Patient Social Security #:	Primary Language Spoken:	If Applicable, Patient Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown	Race: ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ American Indian/Alaskan Native ☐ Unreported/Refused	Patient Served in Military? ☐ No ☐ Yes

Parent/Guardian Full Name (if applicable):	Parent/Guardian Date of Birth: / /

Relationship to Patient:	Is Parent/Guardian a patient of Carevide? ☐ Yes ☐ No

Employer/Occupation:	Employer Phone #:	Need a Translator? ☐ Yes ☐ No If Yes, Language:

Day Phone:	Alternate #:	Email:	Contact Preference: ☐ Day Phone ☐ Alternate ☐ Email ☐ No Contact

How did you hear about us? ☐ Friend ☐ Family ☐ Staff ☐ Internet Search ☐ Facebook ☐ Ad ☐ Insurance ☐ Event ☐ Other:

Homeless? ☐ Yes ☐ No If Yes, need help?	Live in Public Housing? ☐ Yes ☐ No If Yes: ☐ High Rise ☐ Low Rise ☐ Section 8 ☐ Other _____	Migratory / Seasonal Agricultural Worker? ☐ Yes ☐ No

We are here to help in ways you may not realize. We're able to provide resources such as our sliding fee discount. Our sliding fee discount is based on family size and income and helps you if something applies to deductibles, is non-covered, or if insurance is lost. To plan for the future of these resources, we're required to gather the numbers below. Your personal information is not shared and is kept here. **Please complete as best you can**:

Number of Immediate Family in Household: ____ Household Income: $_____ ☐ Monthly ☐ Yearly

Please select one below:

☐ I've completed the above and do not want to see if we're discount eligible; I'll sign a waiver. Should anything change, I'll inform you. Thank you!

☐ I've completed the above and if potentially eligible, please let me know. If we far exceed the range, I know it's available and will sign the waiver. If potentially eligible, I'll bring proof of income by my second visit and will let the scheduler know so there's enough time for the process. Thank you!

INSURANCE INFORMATION PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST.

Primary Insurance: Subscriber Name: Subscriber ID #: Group #:	Subscriber Address (if different): Patient's Relationship to Subscriber: Is Subscriber a Patient Here? ☐ Yes ☐ No	Sub. Daytime #: Sub. Date of Birth: / / Sub. Social Security #:
Secondary Insurance: Subscriber Name: Subscriber ID #: Group #:	Subscriber Address (if different.): Patient's Relationship to Subscriber: Is Subscriber a Patient Here? ☐ Yes ☐ No	Sub. Daytime #: Sub. Date of Birth: / / Sub. Social Security #:

IN CASE OF EMERGENCY

Local Emergency Contact or Primary Caregiver:	Daytime #: Alternate #:	Authorized to Release Information? ☐ Yes ☐ No	Relationship to Patient:	Does Patient Have Advanced Directive or Living Will? ☐ Yes ☐ No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carevide or the insurance company to release any information required to process my claims.

Patient/Parent/Guardian Signature: Today's Date: / /

Patient Acknowledgement

Today's Date	Print Patient's Name	Patient's Birth Date

Acknowledgement of Review of the Notice of Privacy Practices

This notice describes how health information about me may be used and disclosed and how I can get access to this information. I hereby acknowledge that I have been offered and reviewed a copy of Carevide's Notice of Privacy Practices. Effective Date: April 14, 2003; updated with HIPAA Omnibus Rule: September 23, 2013. Initials: _____

Acknowledgement of Review of Patient's Rights and Responsibilities

This notice describes the patient responsibilities to Carevide. I hereby acknowledge that I have been offered and reviewed a copy of Carevide's Patient's Rights and Responsibilities. I agree to all the conditions at Carevide as described in the Patient's Rights and Responsibilities. If I have further questions regarding the Patient Rights and Responsibilities, I may direct questions to the center staff. Initials: _____

Consent for Treatment

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me at the center's service locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations). A person who signs a general consent for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical test or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect. I understand that I will be asked to sign a separate informed general consent for vaccines administered to me and that I will be asked to sign a separate informed consent for the influenza (Flu) vaccine. I understand that there is a separate consent form that I may be asked to sign for procedures performed in the office. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand that this consent is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form. Initials: _____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. **IF** proof of income is provided, you may qualify to use our sliding fee scale for services that are not covered by your insurance or for charges that are applied to your deductible. This does not apply to charges that require a copay or co-insurance payment. Thank you for your cooperation in this matter. Initials: _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. If you no show for three (3) consecutive appointments in a year, you may be discharged from care. The health center will notify you in writing, via certified mail, if you are discharged from care. Initials: _____

Self-Pay

I will be responsible for services rendered at Carevide I agree to pay the full and entire amount for treatment given to me or to the above named patient. I also understand that I will be considered as a "full-pay" patient if proof of income is not provided by my second visit for the sliding fee scale. Initials: _____

Authorization to Release Information

______________ ______________________________ __________________
Today's Date Print Patient's Name Patient's Birth Date

Authorization to Release Information

I hereby authorize any Carevide staff or provider to engage in any verbal or written communication to the person(s) listed below regarding my medical history, medical records, appointments and/or information pertaining to my account and/or billing history with Carevide. I authorize Carevide staff and/or provider to leave health information on a voicemail and/or answering machine at the number(s) listed below. I further authorize Carevide, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Initials: _________

Person(s) Allowed to Receive Personal Health Information Regarding Patient Care

Contact Name: ______________________________ Phone Number: ______________________

Relationship to Patient: __________________________ Date Added: ______________________

Ok to Leave Message: ☐ Yes ☐ No   Ok to Call/Confirm Appt if contact number(s) on file becomes invalid: ☐ Yes ☐ No

Contact Name: ______________________________ Phone Number: ______________________

Relationship to Patient: __________________________ Date Added: ______________________

Ok to Leave Message: ☐ Yes ☐ No   Ok to Call/Confirm Appt if contact number(s) on file becomes invalid: ☐ Yes ☐ No

Contact Name: ______________________________ Phone Number: ______________________

Relationship to Patient: __________________________ Date Added: ______________________

Ok to Leave Message: ☐ Yes ☐ No   Ok to Call/Confirm Appt if contact number(s) on file becomes invalid: ☐ Yes ☐ No

Confirmation of Authorization to Release Information

I have read and understand the above information, and I agree to the terms described. I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient, I certify that I am authorized by law to agree to these conditions of treatment on behalf of the patient.

____ ____________________
Patient/Parent/Guardian Signature Date

____ ____________________
Guarantor Signature (If guarantor is not the patient or parent) *Print Guarantor Name*

Authorization for Use and Disclosure of Health Information

Completion of this document authorizes the use and/or disclosure of the patient's Personal Health Information ("Health Information" or "PHI"), as set forth below, consistent with state and federal laws and regulations concerning the privacy of such Information.

Patient Name: _____ Date of Birth: _____

Use and Disclosure of Health Information defined In 45 C.F.R. § 164.5011 hereby authorize Carevide and center staff to disclose (release) my Personal Health Information (PHI) as noted below:

From: _____ To: _____

Address: _____ _____

_____ _____

Phone: _____ _____

Fax: _____ _____

Complete the following by indicating those items that you want disclosed. If all health info is to be released please check all of the above.

☐ History and Physical ☐ Billing Information ☐ Past/Present Medications ☐ All of the Above

☐ Lab Results ☐ Patient Allergies ☐ Diagnostic Tests

☐ Progress Notes ☐ Discharge Summary ☐ Other: _____

I specifically authorize the disclosure or release of the following information. Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)* _____ Genetic Information (including genetic test results)

_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

I understand that my health Information is being used or disclosed for the following purpose(s):

☐ Treatment/Continuing Medical Care ☐ Personal Use ☐ Billing or Claims ☐ Insurance ☐ School ☐ Employment

☐ Legal Purposes ☐ Disability Determination

Dates of Treatment: _____

This Authorization will expire one (1) year from the date of the signature. Specific Date: _____

Notice of Patient's Rights and Other Information

I understand that I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health Information whose use or disclosure I am hereby authorizing. I acknowledge that Information disclosed pursuant to this authorization may no longer be protected by applicable laws, and could be re-disclosed by the recipient. I understand that have a right to receive a copy of this authorization. I may revoke this authorization at any time, but I must do so in writing and submit it the address below. I understand that my revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Carevide Privacy Officer P.O. Box 1908, Greenville, Texas 75403.

Signature

I have read this release, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the release freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

_____ _____ _____

Print Name Signature of Patient or Personal Representative/Guardian Date

_____ _____ _____ Method: Pick-up / Mail / Fax

Date Requested Requested By Date Records Received

*If mental health Information is requested to be disclosed to a third party by the patient, the physician or other provider who is in charge of the patient must approve the disclosure (release), if the disclosure is not approved by the physician/provider, the reasons must be documented in the patient's medical record.

TO THE PARTY RECEIVING THIS INFORMATION: This Information has been disclosed to you from records whose confidentiality may be protected under federal law. If so, federal regulations (42 CFR, part 11) prohibits you from making any further disclosures of it without specific written consent of the person so whom it pertains, or as otherwise permitted by regulations.

Bright Futures Previsit Questionnaire
Early Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

What changes or challenges have there been at home since last year?

_____

_____

Do you live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ Teeth ☐ Appearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to be active ☐ How your body is changing ☐ Your weight
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ How you are doing in school ☐ Girlfriend or boyfriend ☐ Organizing your time to get things done
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable
Healthy Behavior Choices	☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ Pregnancy ☐ Sexually transmitted infections (STIs) ☐ Decisions about sex and drugs
Violence and Injuries	☐ Car safety ☐ Using a helmet or protective gear ☐ Keeping yourself safe in a risky situation ☐ Gun safety ☐ Bullying or trouble with other kids ☐ Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high?	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Have you ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Growing and Developing

Check off all of the items that you feel are true for you.

- ☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- ☐ I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- ☐ I feel like I have at least one friend or a group of friends with whom I am comfortable.
- ☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
- ☐ I am able to bounce back from life's disappointments.
- ☐ I have a sense of hopefulness and self-confidence.
- ☐ I have become more independent and made more of my own decisions as I have become older.
- ☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

_____

_____

Relationships

Others	Has anybody close to you ever hit or hurt you?	❑ Yes	❑ No	❑ Unsure
	Are you in a relationship with someone you are afraid of?	❑ Yes	❑ No	❑ Unsure

Bright Futures Previsit Questionnaire
Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going.
Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes, describe:

How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)? _____

Questions About Your Child

Vision	Does your child complain that the blackboard has become difficult to see?	☐ Yes	☐ No	☐ Unsure
	Has your child ever failed a school vision screening test?	☐ Yes	☐ No	☐ Unsure
	Does your child hold books close to read?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble recognizing faces at a distance?	☐ Yes	☐ No	☐ Unsure
	Does your child tend to squint?	☐ Yes	☐ No	☐ Unsure
Hearing	Does your child have a problem hearing over the telephone?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble hearing with a noisy background?	☐ Yes	☐ No	☐ Unsure
	Does your child ask people to repeat themselves?	☐ Yes	☐ No	☐ Unsure
	Does your child misunderstand what others are saying and respond inappropriately?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Does your child have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your child's period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Your Growing and Developing Child

Check off all of the items that you feel are true for your child.

- ☐ My child engages in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping herself safe.
- ☐ My child has at least one responsible adult in his life who cares about him and to whom he can go to if he needs help.
- ☐ My child has at least one friend or a group of friends with whom she is comfortable.
- ☐ My child helps others individually or by working with a group in school, a faith-based organization, or the community.
- ☐ My child is able to bounce back from life's disappointments.
- ☐ My child has a sense of hopefulness and self-confidence.
- ☐ My child has become more independent and made more of his own decisions as he has become older.
- ☐ My child is particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	Name

DRUG ALLERGIES	CURRENT MEDICATIONS	ID NUMBER

WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	BIRTH DATE	AGE
					☐ M ☐ F

Visit with: ☐ Teen alone ☐ Parent(s) alone ☐ Mother ☐ Father ☐ Teen with parents ☐ Other _____

History

☐ Previsit Questionnaire reviewed
☐ Teen has a dental home
☐ Teen has special health care needs

Concerns and questions ☐ None ☐ Addressed (see other side)

Follow-up on previous concerns ☐ None ☐ Addressed (see other side)

Interval history ☐ None ☐ Addressed (see other side)

Menarche: Age _____ Regularity _____

Menstrual problems _____

☐ Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Changes since last visit _____

Teen lives with _____

Relationship with parents/siblings _____

Risk Assessment

If not reviewed in Supplemental Questionnaire (Use other side if risks identified.)

HOME
- Eats meals with family ☐ Yes ☐ No
- Has family member/adult to turn to for help ☐ Yes ☐ No
- Is permitted and is able to make independent decisions ☐ Yes ☐ No

EDUCATION
- Grade _____
- Performance ☐ NL _____
- Behavior/Attention ☐ NL _____
- Homework ☐ NL _____

EATING
- Eats regular meals including adequate fruits and vegetables ☐ Yes ☐ No
- Drinks non-sweetened liquids ☐ Yes ☐ No
- Calcium source ☐ Yes ☐ No
- Has concerns about body or appearance ☐ Yes ☐ No

ACTIVITIES
- Has friends ☐ Yes ☐ No
- At least 1 hour of physical activity/day ☐ Yes ☐ No
- Screen time (except for homework) less than 2 hours/day ☐ Yes ☐ No
- Has interests/participates in community activities/volunteers ☐ Yes ☐ No

DRUGS (Substance use/abuse)
- Uses tobacco/alcohol/drugs ☐ Yes ☐ No

SAFETY
- Home is free of violence ☐ Yes ☐ No
- Uses safety belts/safety equipment ☐ Yes ☐ No
- Has peer relationships free of violence ☐ Yes ☐ No

SEX
- Has had oral sex ☐ Yes ☐ No
- Has had sexual intercourse (vaginal, anal) ☐ Yes ☐ No

SUICIDALITY/MENTAL HEALTH
- Has ways to cope with stress ☐ Yes ☐ No
- Displays self-confidence ☐ Yes ☐ No
- Has problems with sleep ☐ Yes ☐ No
- Gets depressed, anxious, or irritable/has mood swings ☐ Yes ☐ No
- Has thought about hurting self or considered suicide ☐ Yes ☐ No

Physical Examination

☑=NL

Bright Futures Priority
- ☐ **SKIN**
- ☐ **BACK/SPINE**
- ☐ **BREASTS**
- ☐ **GENITALIA**
- **SEXUAL MATURITY RATING** _____

Additional Systems
- ☐ GENERAL APPEARANCE
- ☐ HEAD
- ☐ EYES
- ☐ EARS
- ☐ NOSE
- ☐ MOUTH AND THROAT
- ☐ NECK
- ☐ TEETH
- ☐ LUNGS
- ☐ HEART
- ☐ ABDOMEN
- ☐ EXTREMITIES
- ☐ NEUROLOGIC

Abnormal findings and comments _____

Assessment

☐ Well teen

Anticipatory Guidance

☐ Discussed and/or handout given

☐ PHYSICAL GROWTH AND DEVELOPMENT
- Brush/Floss teeth
- Regular dentist visits
- Body image
- Balanced diet
- Limit TV
- Physical activity

☐ SOCIAL AND ACADEMIC COMPETENCE
- Help with homework when needed
- Encourage reading/school
- Community involvement
- Family time
- Age-appropriate limits
- Friends

☐ EMOTIONAL WELL-BEING
- Decision-making
- Dealing with stress
- Mental health concerns
- Sexuality/Puberty

☐ RISK REDUCTION
- Tobacco, alcohol, drugs
- Prescription drugs
- Know friends and activities
- Sex

☐ VIOLENCE AND INJURY PREVENTION
- Seat belts, no ATV
- Guns
- Safe dating
- Conflict resolution
- Bullying
- Sport helmets
- Protective gear

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ **Vision**

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

Psychosocial Risks
Confidential (To be completed confidentially for teens with identified risk)

Home

Relationship with parents/guardians _____

Violence in home _____

Teen's concerns _____

Autonomy _____

Counseling/Recommendations _____

Education

Teen's concerns _____

Social interactions _____

Conflicts _____

Counseling/Recommendations _____

Eating

Usual diet _____

Attempts to lose weight by dieting, laxatives, or self-induced vomiting _____

Regular meals (includes breakfast, limits fast food) _____

Counseling/Recommendations _____

Activities

Clubs/Extracurricular _____

Music/Art _____

Sports _____

Religious/Community _____

TV/Electronics _____ hours/day

Gangs _____

Counseling/Recommendations _____

Drugs (Substance Use/Abuse)

Tobacco use _____

Alcohol _____

Drugs (street/prescription) _____

Steroids _____

CRAFFT (+2 indicates need for follow-up)

C – Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? ☐ Yes ☐ No

R – Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? ☐ Yes ☐ No

A – Do you ever use alcohol or drugs while you are by yourself, ALONE? ☐ Yes ☐ No

F – Do you ever FORGET things you did while using alcohol or drugs? ☐ Yes ☐ No

F – Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? ☐ Yes ☐ No

T – Have you gotten into TROUBLE while you were using alcohol or drugs? ☐ Yes ☐ No

Counseling/Recommendations _____

Safety

Bullying _____

Guns _____

Dating violence _____

Passenger safety _____

Sports/recreation safety _____

Counseling/Recommendations _____

Sex

Oral sex ☐ Yes ☐ No

Has had sexual intercourse (vaginal, anal) ☐ Yes ☐ No

Age of onset of sexual activity _____

Number of partners _____ Gender of partners ☐ Male ☐ Female

Sexual orientation _____

Condom use _____ Contraception _____

Previous pregnancy ☐ No ☐ Yes _____

Previous STI ☐ No ☐ Yes _____

Laboratory/Screening results

☐ Pregnancy test ☐ Pap smear

☐ Chlamydia/Gonorrhea, source _____ ☐ Syphilis ☐ HIV

STI screening laboratory results (specify) _____

Counseling/Recommendations _____

Suicidality/Mental Health

Depression ☐ No ☐ Yes—when? _____

Anxiety ☐ No ☐ Yes—when? _____

Suicide ideation ☐ No ☐ Yes—when? _____

Suicide attempts ☐ No ☐ Yes—when? _____

History of psychologic counseling ☐ No ☐ Yes—when? _____

Other mental health diagnosis _____

Counseling/Recommendations _____

Confidentiality discussed ☐ With teen ☐ With parent(s)

CRAFFT used with permission from Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med.* 2002;156:607–614

HEEADSSS used with permission from Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr.* 2004;21:64–90

This American Academy of Pediatrics Visit Documentation Form is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

Bright Futures Patient Handout
Early Adolescent Visits

PHYSICAL GROWTH AND DEVELOPMENT

Your Growing and Changing Body

- Brush your teeth twice a day and floss once a day.
- Visit the dentist twice a year.
- Wear your mouth guard when playing sports.
- Eat 3 healthy meals a day.
- Eating breakfast is very important.
- Consider choosing water instead of soda.
- Limit high-fat foods and drinks such as candy, chips, and soft drinks.
- Try to eat healthy foods.
  - 5 fruits and vegetables a day
  - 3 cups of low-fat milk, yogurt, or cheese
- Eat with your family often.
- Aim for 1 hour of moderately vigorous physical activity every day.
- Try to limit watching TV, playing video games, or playing on the computer to 2 hours a day (outside of homework time).
- Be proud of yourself when you do something good.

RISK REDUCTION

Healthy Behavior Choices

- Find fun, safe things to do.
- Talk to your parents about alcohol and drug use.
- Support friends who choose not to use tobacco, alcohol, drugs, steroids, or diet pills.
- Talk about relationships, sex, and values with your parents.
- Talk about puberty and sexual pressures with someone you trust.
- Follow your family's rules.

EMOTIONAL WELL-BEING

How You Are Feeling

- Figure out healthy ways to deal with stress.
- Spend time with your family.
- Always talk through problems and never use violence.
- Look for ways to help out at home.
- It's important for you to have accurate information about sexuality, your physical development, and your sexual feelings. Please consider asking me if you have any questions.

SOCIAL AND ACADEMIC COMPETENCE

School and Friends

- Try your best to be responsible for your schoolwork.
- If you need help organizing your time, ask your parents or teachers.
- Read often.
- Find activities you are really interested in, such as sports or theater.
- Find activities that help others.
- Spend time with your family and help at home.
- Stay connected with your parents.

VIOLENCE AND INJURY PREVENTION

Violence and Injuries

- Always wear your seatbelt.
- Do not ride ATVs.
- Wear protective gear including helmets for playing sports, biking, skating, and skateboarding.
- Make sure you know how to get help if you are feeling unsafe.
- Never have a gun in the home. If necessary, store it unloaded and locked with the ammunition locked separately from the gun.
- Figure out nonviolent ways to handle anger or fear. Fighting and carrying weapons can be dangerous. You can talk to me about how to avoid these situations.
- Healthy dating relationships are built on respect, concern, and doing things both of you like to do.

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Bright Futures Parent Handout
Early Adolescent Visits

Here are some suggestions from Bright Futures experts that may be of value to your family.

PHYSICAL GROWTH AND DEVELOPMENT

Your Growing and Changing Child

- Talk with your child about how her body is changing with puberty.
- Encourage your child to brush his teeth twice a day and floss once a day.
- Help your child get to the dentist twice a year.
- Serve healthy food and eat together as a family often.
- Encourage your child to get 1 hour of vigorous physical activity every day.
- Help your child limit screen time (TV, video games, or computer) to 2 hours a day, not including homework time.
- Praise your child when she does something well, not just when she looks good.

RISK REDUCTION

Healthy Behavior Choices

- Help your child find fun, safe things to do.
- Make sure your child knows how you feel about alcohol and drug use.
- Consider a plan to make sure your child or his friends cannot get alcohol or prescription drugs in your home.
- Talk about relationships, sex, and values.
- Encourage your child not to have sex.
- If you are uncomfortable talking about puberty or sexual pressures with your child, please ask me or others you trust for reliable information that can help you.
- Use clear and consistent rules and discipline with your child.
- Be a role model for healthy behavior choices.

EMOTIONAL WELL-BEING

Feeling Happy

- Encourage your child to think through problems herself with your support.
- Help your child figure out healthy ways to deal with stress.
- Spend time with your child.
- Know your child's friends and their parents, where your child is, and what he is doing at all times.
- Show your child how to use talk to share feelings and handle disputes.
- If you are concerned that your child is sad, depressed, nervous, irritable, hopeless, or angry, talk with me.

SOCIAL AND ACADEMIC COMPETENCE

School and Friends

- Check in with your child's teacher about her grades on tests and attend back-to-school events and parent-teacher conferences if possible.
- Talk with your child as she takes over responsibility for schoolwork.
- Help your child with organizing time, if he needs it.
- Encourage reading.
- Help your child find activities she is really interested in, besides schoolwork.
- Help your child find and try activities that help others.
- Give your child the chance to make more of his own decisions as he grows older.

VIOLENCE AND INJURY PREVENTION

Violence and Injuries

- Make sure everyone always wears a seat belt in the car.
- Do not allow your child to ride ATVs.
- Make sure your child knows how to get help if he is feeling unsafe.
- Remove guns from your home. If you must keep a gun in your home, make sure it is unloaded and locked with ammunition locked in a separate place.
- Help your child figure out nonviolent ways to handle anger or fear.

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TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**