William Newton
HILLSIDE
FAMILY MEDICINE

Welcome to our Clinic

Patient First Name	Middle Name	Last Name
Date of Birth	Pediatric	Social Security Number

Gender: Male Female	Race	Marital Status: S M W D Separated
Preferred Contact Method: Email Phone Postal Patient Portal	Appt. Notification Contact Method: Email Text Call Primary Call Cell Call Work	Email

Street Address	City	State	Zip

Primary Phone #	Work Phone #	Mobile/Other Phone #

Emergency Contact Last Name, First Name	Relationship	Phone #

Guarantor Name		Patient's Relationship to Guarantor
Date Of Birth	Social Security #	Address
Primary Phone #	Work Phone #	Employer

Employer	Occupation	City, State, ZIP

Insurance Information	Secondary Insurance Name
Insurance Company:	Insurance Company:
Policy #:	Policy #
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Please Check here if NO Insurance: ☐	Please Check here if NO Insurance: ☐

William Newton HILLSIDE FAMILY MEDICINE

Patient Name	DOB	Peds	Age

PERSONAL MEDICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

ADHD	Behavior Problems	Learning Disabilities	
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Seizure Disorder
Anxiety	Eczema	Liver Disease	Thyroid Disorder
Asthma	GERD	Crohn's Disease	
Bladder Problems	Heart Disease	High Cholesterol	
Constipation	Hernia		**Other not listed:**
Headaches	Umbilical Hernia		
Kidney Disease	High Blood Pressure		

Allergies:

Drugs:
Food
Other: (bees, pets, etc.)

Gestational weeks	
Birth weight and length	
Are immunizations up to date? (please provide record)	
Method of delivery	
Diet (breast or formula)	

Patient Name	DOB	Peds	Age

SURGICAL HISTORY: PLEASE LIST ALL PRIOR SURGERIES AND APPROXIMATE DATES PERFORMED:

Surgery	Date

HOSPITAL ADMISSIONS OR RECENT EMERGENCY ROOM VISITS THIS YEAR: Month / Year

SOCIAL HISTORY

13 + Years	Frequency
Tobacco Use	
Alcohol Use	
Drug Use	
Caffeine	
Exercise	

Medication	Dosage	Frequency

Patient Name	DOB	Peds	Age

Preferred Pharmacy:

Pharmacy Name:	**Address**	**Phone Number**

CULTURAL HISTORY:

Elementary	High School			

Do you have any vision problems that affect your communication? ☐Yes or ☐No

Do you have hearing problems that affect your communication? ☐Yes or ☐No

Do you have any limitations to understanding and / or following instructions? ☐Yes or ☐No

Who does the child live with:

Who lives in the home:

Any secondhand smoke exposer?

List any family medical history:

Family History	Mother	Father	Siblings	Grandparents
Asthma				
Allergies				
Diabetes				
Heart Issues				
Other:				

Patient Name	DOB	Peds	Age

Authorization to release information:
I authorize for information regarding my medical care to be released to the following person(s) if he or she so requests:

Name	Relationship to patient	Phone number

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any information required for claim(s) submission to my insurance company(s). I also authorize that payments be made directly to William Newton Hillside Family Medicine.

Signature: _____ Date: _____

Parent, if minor: _____ Date: _____

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CONSENT TO TREAT A MINOR

To Parents and Guardians of Minor Children:

The providers and staff of William Newton Hillside Family Medicine emphasize the health and well-being of each and every patient in our clinic. We appreciate that you have entrusted us to provide health care services to your minor child and we look forward to working with you to ensure that your child receives the best health care possible.

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). With so many parents working outside of the home or with other commitments, we realize that you may not be able to accompany your child on every visit to the clinic. If your minor child presents to the clinic unaccompanied, we will not be able to see the unaccompanied minor. If the minor presents in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If they do not have consent for treatment, the appointment will be rescheduled. In an effort ro provide the care needed and avoid having to reschedule your child's appointment, we have developed a Consent to Treat a Minor form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child when deemed necessary by qualified medical personnel. Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present photo ID upon checking the patient in for the appointment. This consent form will remain in effect until revoked in writing. You may request this form from any member of our clinic staff.

By law, minors have the right to consent to certain health care without a parent or guardian's consent. A minor may consent to treatment:

- if the minor is emancipated (legally independent) or married to someone at or above age 18
- in the event emergency care is necessary
- for birth control and pregnancy-related care at any age
- for outpatient drug and alcohol abuse-related treatment beginning at age 13
- for outpatient mental health treatment beginning at age 13
- for sexually transmitted diseases, including HIV, beginning at age 14

If a minor consents to care as allowed by law, he or she can request confidentiality for that aspect of care which would prohibit us from releasing this information to anyone, including a parent or guardian, without the minor's express written permission. It is the philosophy of this clinic to encourage minor patients to include a parent, guardian or other trusted adult in all aspects of their health care, including those areas noted above. For legal and other reasons, parent or guardian involvement may not always be possible. Rest assured that we would continue to provide health care services that are in the best interest of your minor child.

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Patient Name _____ Date of Birth _____/_____/_____

I, the undersigned, parent(s) or legal guardian(s) of the above-named patient, a minor, do hereby authorize the physicians at William Newton Hillside Family Medicine to act as agents for the undersigned to consent to physical examination, medical diagnosis and treatment or other medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, the treating physician who is licensed to practice in the state of Kansas, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital. I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance. In an emergency, it is understood that authorization is granted to the physicians at William Newton Hillside Family Medicine in advance of any specific diagnosis, treatment or hospital care rendered to the above-named patient. Authorization is granted to provide authority and power on the part of the physicians to provide all such medical or surgical diagnosis, treatment or hospital care which the above-mentioned physicians, in the exercise of his or her best judgment, may deem advisable.

Consent to treat a minor child accompanied by an adult other than the child's parent or legal guardian

I, the parent or legal guardian of the patient named above, do hereby authorize the physicians at William Newton Hillside Family Medicine to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's Name _____

Relationship to Minor Patient _____

This authorization is valid:

□ For any and all medical treatment, including: preventative care, school/sports physicals & vaccines for today's visit only _____/_____/_____

□ For this specific problem list or date range. Please specify _____

This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.

Parent/Legal Guardian (print) _____ Date ___/___/____

Parent/Legal Guardian Signature _____

Witness Printed Name _____

Witness Signature _____

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AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone Number: _____ Other Names Used: _____

Name of Guardian or Legal Representative: _____

Person/Facility/Organization Authorized to Release Information:

_____

Person/Facility/Organization Authorized to Received Information:
William Newton Hillside Family Medicine Address: 1700 E Ninth, Winfield, KS 67156
Phone Number: 620-221-0110 Fax Number: 620-221-0623

The following health information that relates to services beginning on:

_____ to _____ may be released

□ Complete Chart □ Visit Notes □ Patient Summary □ Lab Results

□ X-Ray Results □ Itemized Bill □ Other

Reason for Disclosure:
□ Continuum of Patient Care □ Transfer of Patient Care □ Personal

This authorization is valid for one year following the date of my signature below.

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization or my insurance company when the law provides my insurer with the right to contest a claim under my policy.

- Unless otherwise revoked, this authorization shall remain in effect for one year from today's date or on the expiration date indicated above for records generated as a result of services occurring on or prior to this date.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially laws.

_____ _____
Signature of Patient or Legal Representative Date

Relationship to patient: _____