4810 Whitesport Circle, Suite 100
Huntsville, AL 35801

Erik Henninger, DO
Andrea Reynolds, MD
Kristina Morris, CRNP

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ ALT PHONE: _____

DATE OF BIRTH: _____/_____/_____ ☐ MALE ☐ FEMALE

PHARMACY NAME: _____ PHONE: _____

PREVIOUS PHYSICIAN: _____ CITY/STATE: _____

PREVIOUS PHYSICIAN PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____ EMAIL: _____

OTHER CONTACTS: _____

PATIENT CALL BACK SURVEY: ☐ YES ☐ NO CALL: ☐ HOME ☐ CELL ☐ OTHER: _____

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY NAME: _____

ID #: _____ GROUP #: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

DOB: _____/_____/_____ PHONE #: _____

SECONDARY

INSURANCE COMPANY NAME: _____

ID #: _____ GROUP #: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

DOB: _____/_____/_____ PHONE #: _____

Payment is expected at the time of the visit, unless other arrangements are made in advance. You are responsible for all deductibles, co-insurance, and any fees not covered under your insurance policy. Thank you.

GUARDIAN SIGNATURE: _____ DATE: _____

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PATIENT HEALTH QUESTIONNARE

Today's Date: _____ Preferred Pharmacy: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Guardian's Name: _____

Name & Birthday of Sibling(s):

_____ _____

_____ _____

_____ _____

Patient's Current School & Grade: _____

PAST MEDICAL HISTORY

Allergies: _____

Current Medications: _____

Chronic/Current Conditions: _____

Past Surgeries (please list with date): _____

_____

FAMILY HISTORY

Please indicate any diseases that are in the family and who was affected (check all that apply).

☐ Asthma ☐ High Blood Pressure ☐ Sickle Cell Disease or trait

☐ Cancer ☐ Kidney Problems ☐ Diabetes

☐ Stoke ☐ High Cholesterol ☐ Seizure Disorders

☐ Birth Defects ☐ Heart Disease (heart attack, stents, pacemaker, heart catheterization, etc.)

☐ Other: _____

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MEDICAL CONSENT FORM

In consideration of the care given and to be given to me:

Patient Name: _____ DATE OF BIRTH: _____/_____/_____

I hereby give consent to receive medical treatment, including medications and hospitalization.

I hereby give consent to use such necessary examinations, injections, tests, or immunizing treatments as in the opinion of the attending physician.

I hereby authorize the release of any requested medical information from private physicians and/or institutions.

Patient Signature / Legal Guardian, if a minor: _____

Relationship to Patient: _____

Date: _____

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PATIENT CONSENT FOR E-PRESCRIBING (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give consent to my providers to see this protected health information.

Patient / Guardian Signature: _____

Date: _____ Time: _____

Relationship to Patient: _____

Interpreter, if utilized: _____

Witness Signature: _____

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I _____ hereby give consent for the following people to authorize medical treatment of my child _____ and to accompany them to the office visit at Crestwood Medical Group, Pediatrics Huntsville.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient / Guardian Signature: _____

Date: _____

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OFFICE POLICY ON LATE ARRIVAL

We value your time and we understand sometimes late arrival cannot be helped.

In an effort to keep our schedule and reduce patient wait time, please be advised that there is a 15 minute grace period beyond your scheduled appointment.

After the 15 minute grace period you may be seen at the doctor's discretion, or you may be asked to reschedule for the next available appointment.

Please ask to see our office manager if you have any questions relating to this policy.

Thank you,

The Staff of Crestwood Medical Group, Pediatrics Huntsville

Signature: _____

Witnessed By: _____