Advocate Children's Hospital

CHICAGOLAND & NORTHWEST INDIANA
RONALD MCDONALD HOUSE CHARITIES

Ronald McDonald Care Mobile

Patient Demographic Information and Patient Agreements & Authorizations Form

General Patient Information:

Child's Full Name	Child's Date of Birth Child's Age	Child's Sex □ Male □ Female
Child's Address	City/State	Zip Code
Child's School Child's Grade	Child's Race (mark all that apply) □ African-American □ Caucasian □ Asian □ Hispanic □ Other _____	Child's Preferred Language
Parent/Legal Guardian's Full Name	Best Daytime Contact Number	

Doctor/Insurance Information

Child's **Regular/Primary doctor**	Doctor's Address	Doctor's Phone Number
Which type of insurance does your child have (please circle)? Medicaid/Public Insurance No Insurance Private Insurance (PPO/HMO)		Doctor's Fax Number □ child does NOT have a PCP

Immunization Information

Please list any REQUIRED immunizations you do NOT want your child to receive
Please mark which RECOMMENDED immunizations you do or do not want you child to receive **Flu vaccine** □ Yes □ No Hepatitis A Vaccine (2 dose series) □ Yes □ No HPV (Human Papilloma Virus) vaccine □ Yes □ No (2 does series if 11-15, 3 dose series if 15 or older)

May your child receive free healthy snack items (may contain nuts, soy, dairy, egg or gluten)? □ Yes □ No

CONSENT FOR TREATMENT: I do consent/permit to the treatment provided by Advocate Physicians, Nurses or other designated health care providers. I understand that Physicians, Nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my child's treatment and I consent/permit to such student involvement. This treatment can include physical examination, health screenings and all recommended and required immunizations except where declined above.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:

- I authorize/allow the use and disclosure of this personal health information (PHI) for the purposes of diagnosing or providing treatment to my child, obtaining payment for care, or for health care business management of Advocate Medical Group.
- I authorize/allow Advocate to release information required in the process of applications for financial coverage for services. This authorization provides that Advocate may release specific clinical information related to my child's diagnoses and treatment, which may be requested by an insurance company or its representative.
- I authorize Advocate to provide my child's educational institution/school with a copy of the health exam and to include immunizations administered.
- I authorize Advocate to release information from the visit to the primary health care provider/doctor provided above.

DISCLAIMER: This Ronald McDonald Care Mobile is made possible by a grant from the Ronald McDonald House Charities, Inc. ("RMHC"), a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

Patient's Parent/Guardian: _____ Date: _____