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:** _____

Advocate Children's Hospital

1675 W. Dempster ~ Park Ridge, IL 60068
Phone 847-723-7358 ~ Fax 847-723-9566

Ronald McDonald Care Mobile

CHICAGOLAND & NORTHWEST INDIANA
Ronald McDonald House Charities

4440 W. 95th Street ~ Oak Lawn, IL 60453
Phone 847-723-7358 ~ Fax 708-684-4763

Child History Form

*****Please complete as much information as possible for us to best care for your child*****

Child's Name	Date of Birth
Last visit to regular doctor	Reason
Last visit to dentist	Last vision test

How many days has the child missed from school in the past year? _____ Reason(s)_____
Were any because the required physical or immunizations were not complete? □ Yes □ No

Has the child been in the Emergency Room in the past year? □ Yes □ No
If yes, please list reasons: _____

Has the child had any overnight hospitalizations or any surgeries? □ Yes □ No If yes, please list: _____

Please list the child's medications: _____

Please list allergies to any medication/foods/other: _____

Has the child had any reaction to previous immunizations: (please circle)
NONE fever (104 or more) seizure severe allergic reaction rash change in mental status

Does the child have any health problems or major illnesses below?

Asthma	□ Yes □ No	Diabetes	□ Yes □ No
Birth defects	□ Yes □ No	Heart problem (heart murmur, high blood pressure)	□ Yes □ No
Ear infections	□ Yes □ No	Constipation	□ Yes □ No
Sickle cell/hemophilia	□ Yes □ No	Dizziness or chest pain with exercise	□ Yes □ No
Bone/joint problems	□ Yes □ No	Ear/hearing problems	□ Yes □ No
Developmental delay	□ Yes □ No	Eye or vision problems, wears glasses or contacts	□ Yes □ No
Behavioral concerns	□ Yes □ No	Other (please list):	

Child's Family History: Place the letter of family member who has each problem on chart below—**M**other, **F**ather, **S**ister, **B**rother, **G**randparent

Heart disease	Asthma	High blood pressure	Cancer
Stroke	Seizures	Diabetes	Sudden death before age 50

Please mark yes or no for the following statements:

□ Yes □ No In the past 12 months, our family has run out of food before we had money to buy more
□ Yes □ No In the past 12 months, our family has worried we would not have enough food before we had money to buy more
□ Yes □ No The child is exposed to cigarette smoke in the home
□ Yes □ No There is a gun in the home where the child lives or spends a lot of time
□ Yes □ No The child wears a seat belt in the car
□ Yes □ No The child owns a bike helmet
□ Yes □ No The child is in need of mental health/behavioral health resources

Please list anything else you would like us to know about the child or any special concerns?
_____

Printed name	**Date:**
Parent/legal guardian signature	