Oakwood
Adams Child & Adolescent Health Center
Romulus Teen Health Center
Taylor Teen Health Center
Westwood Teen Health Center

Date

PATIENT INFORMATION SHEET

PATIENT

Patient's Name			Birth Date	Age
Street Address	City		State	Zip Code
	Sex: ☐ M ☐ F	Social Security Number	Home Phone	Other Phone

Race: ☐ American Indian/Alaskan Native ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Unknown ☐ NonHispanic

Language Spoken in Home

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married

If Student, current grade	Name of School	
Family Physician's Name	Address	Phone No.

How did you hear about our health center?

EMERGENCY

IN CASE OF EMERGENCY, *please given name, address and phone number of a friend or relative not living at your address:*

Name	Relationship to you
Address, City, State and Zip	Phone Number

INSURANCE

Primary Insurance Carrier			Secondary Insurance Carrier		
Subscriber Name			Subscriber Name		
Relationship to patient	Social Security No.	Date of Birth	Relationship to patient	Social Security No.	Date of Birth
Employer		Business Phone	Employer		Business Phone
Contract #			Contract #		
Group #	Service Code		Group #	Service Code	

PARENT

PATIENT'S INFORMATION (If patient is under 18 or insurance is in parent's name please fill out following

FATHER OR GUARDIAN			MOTHER OR GUARDIAN		
Name			Name		
Business Phone	Home Phone	Birth Date	Business Phone	Home Phone	Birth Date
Other Phone	Social Security Number		Other Phone	Social Security Number	
Driver's License Number			Driver's License Number		

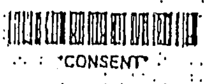
Oakwood

Westwood Teen Health Center
25912 Annapolis St
Inkster, MI 48141
313.565.2174

River Rouge Teen Health Center
1460 W. Coolidge Hwy
River Rouge, MI 48218
313.843.1839

Taylor Teen Health Center
26650 Eureka Road
Suite B
Taylor, MI 48180
734.942.2273

Romulus Teen Health Center
9650 Wayne Rd
Romulus, MI 48174
734.942.4057



NAME:

MR #:

BIRTHDATE:

PATIENT/PARENT CONSENT TO TREATMENT

Patient Name:______________________ Birth Date:______________

J117200 Rev. 10/00 3/14 7/15

SECTION 1

The Oakwood Teen Health Centers provide a wide range of medical care, metal health care and health education services to adolescents and young adults, including: physicals, immunizations, sick care, first aid, lab tests and prescriptions, skin and nutrition care- hearing and vision screening, sexually transmitted infection diagnosis and treatment, HIV counseling and testing, reproductive health education and referral, individual and group counseling and referral and substance abuse prevention, assessment and referral. Services are rendered without regard to Sex, race, religion or sexual orientation.

The Oakwood Teen Health Centers measure the patient's height and weight and record that information in the Michigan Care Improvement Registry's (MCIR) Body Mass Index (BMI) Growth Module. Oakwood Teen Health Centers use the resources and tools in the module to promote healthy weight and lifestyle habits for our patients. Use of the module is optional and you may choose to decline this service. Let us know if you decline.

I consent to allow the Oakwood Teen Health Centers to provide treatment, including but not limited to the services listed above, as the physician and health care staff of the Teen Health Center consider necessary I understand that I can withdraw my consent at any time by giving notice in writing. If I am signing as a parent/guardian, this consent is valid until the patient turns age 18.

I understand that Michigan law does not require a parent to consent for a minor to receive advice or treatment of drug abuse, alcoholism, sexually transmitted diseases, including HIV, reproductive health care, or outpatient counseling. At the health providers discretion, a parent may be notified if the situation is dangerous or life threatening.

I understand that testing for blood borne diseases, including HIV, may be performed without a separate written consent if a health professional, volunteer, student or employee of Oakwood is exposed to the patient's blood or body fluids through skin, mucous membrane, or open wound.

SECTION 2

Immunizations and Vaccinations - I understand my child's immunization (shot) records from the schools and the Michigan Care Improvement Registry will be reviewed <u>If it is determined that my child needs a required shot, I give my permission for it to be given at the Oakwood Teen Health Center.</u> I understand a letter with the needed shot and a vaccine Information Sheet will be sent home for my review at least 1 week before the immunization is planned, or given to me at the clinic the day the immunization is given. The required shots include DTap/DT/TD/Tdap, Hepatitis B, IPV (polio), Meningococcal (Meningitis), Measles, Mumps, and Rubella (MMR), and Varicella (Chicken Pox). The recommended shots include: Hepatitis A HPV(gardasil) and Influenza (flu). If I agree, I understand that at any time I no longer want my child to be immunized, I can contact the clinic and withdraw, the consent.

☐ Yes, I agree ☐ No, I do not agree, Please initial__________

SECTION 3

Authorization to Pay Insurance Benefits to the Oakwood Teen Health Centers and Release of Information
I authorize my insurance carrier to pay the Oakwood Teen Health Centers for services rendered to me/my child that are covered under my health insurance plan. I understand I may be responsible for fees and charges if my health care provider does not participate in my health insurance plan. I also understand I may be responsible for fees and charges that are co-pays, deductibles, or that are for services that are not covered under my health insurance plan. I also authorize the Oakwood Teen Health Centers to release medical information to any Oakwood Healthcare System hospital, facility, entity or physician, or me/my child's primary health care provider for continuity of care. A copy of this authorization may be used in place of the original. I understand that I or my insurance carrier may withdraw this authorization at any time by giving notice in writing. I also understand that the facility will protect the information in my medical record, but then from time to time the facility must release information regarding the care provided to state or federal regulators. I understand that if a test for certain sexually transmitted infections is positive, the law requires the reporting of the positive result to a public health agency.

I consent for treatment as stated in above Sections 1 2 and 3.

Signature of Parent / Guardian ______________________ Date __________

Patient ______________________ Date __________

Parental consent to withdraw care or treatment from the Oakwood Teen Health Centers.
☐ Medical ☐ Mental Health

Signature of Parent / Guardian ______________________ Date __________

Oakwood

CHILD & ADOLESCENT HEALTH CENTER

NAME:

M.R. #:

BIRTHDATE:

PARENT/GUARDIAN/ADOLESCENT INITIAL HEALTH HISTORY QUESTIONNAIRE

ADOLESCENT INFORMATION

Why did you come to the clinic today? ______________________________

____

Sex ☐ Male ☐ Female Age__________ Grade in School __________ Year in college __________

Language(s) spoken in your home: ______________________________

ADOLESCENT MEDICAL HISTORY

Are you allergic to any medicines? ☐ Yes ☐ No Name of medicine ____________________

Are you taking any medicine now? ☐ Yes ☐ No Name of medicine ____________________

Do you have any health problems? ☐ Yes ☐ No Problem ____________________

Have you ever been hospitalized overnight? ☐ Yes ☐ No

If yes, give age hospitalized and describe problem Age________ Problem ____________________

Age________ Problem ____________________

Have you ever had any of the following illnesses or problems? If yes, check all that apply:

- ☐ Allergies
- ☐ Anemia or blood disorders
- ☐ Asthma
- ☐ Bladder/kidney infections
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Endocrine/gland disease
- ☐ Hepatitis
- ☐ Headaches/migraines
- ☐ Mental illness or depression
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Rheumatic fever/heart disease
- ☐ Scoliosis
- ☐ Seizures
- ☐ Severe acne
- ☐ Sports injuries or broken bones
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer or digestive problems
- ☐ Other______________________________

FAMILY HISTORY

Please check (✓) below if any of the adolescent's blood relatives, living or deceased, have ever had any of the following problems? (e.g., Place ✓ in column headed "F" if adolesent's father had asthma) See below for column heading explanations.

O = None **F = Father** **GP = Grandparent**
M = Mother **S/B = Sister/Brother** **A/U = Aunt/Uncle**

	O	M	F	S/B	GP	A/U		O	M	F	S/B	GP	A/U
Allergies							Endocrine/gland disease						
Arthritis							Heart attack/stroke/sudden dealth before age 55						
Asthma							Heart attack/stroke after age 55						
Bleeding disorders/Sickle cell anemia							High blood pressure						
Birth defects							High cholesterol						
Cancer							Kidney disease						
Developmental delay or retardation							Lung disease/tuberculosis						
Depression/Suicide/ Mental health problems							Seizures						
Diabetes							Substance abuse (alcohol or drug problem)						
Eating disorders							Smoking						
Other (specify)													

Comments ______________________________

____

Provider Signature______________________________ Date/Time __________

3039331 (6/11)

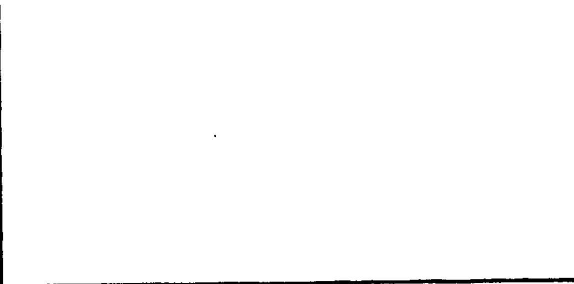
Permission to Communicate my Health Information Electronically

Rx History Consent

I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to: determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient Signature ______________________________ Date ________________

Parent Signature ______________________________ Date ________________



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Oakwood Healthcare Notice of Privacy Practices. I understand this Notice provides me with information on my privacy rights and how my health information may be used and disclosed.

_______________________________________ _______________
Signature of Patient or Representative Date

____
Relationship to Patient

____
Printed or Typed Name

_______________________________________ _______________
Witness or Signature of Oakwood Employee Date

If the patient does not sign this acknowledgement, please identify what effort was made to obtain an acknowledgement:

- ☐ Patient given a copy of the Notice but refused to sign form.
- ☐ Patient unable to sign related to:
  - ☐ Emergency treatment situation
  - ☐ Unconscious
  - ☐ Mentally Incompetent
  - ☐ Language Barrier
  - ☐ Other (explain): _______________________________________

____

____

_______________________________________ _______________
Signature of Oakwood Employee Date

J126230 (4/03)