BIENVILLE
FAMILY CLINIC

Information & Medical History

School: _____ Grade: _____

Child's Name: _____

_____Male _____Female Birthdate_____SS#_____

Does your child have a regular Physician or other Provider?_____YES_____NO

Name of Physician: _____

Physician Office Phone#: _____ Date of Last Exam: _____

Medicaid/Bayou Health Plan Number Information

Child ID Number: _____

Bayou Health Plan Name:

_____Amerigroup _____Amerihealth _____United HealthCare _____Aetna
_____La Healthcare Connections
Medicaid #_____
Bayou Health Plan #:_____
_____No Insurance
_____Private/Other insurance company name_____
Company Address:_____
Policy #: _____
Name of Policy holder: _____Relationship to student:_____
Policy Holder DOB:_____Policy Holder SS#:_____
Does your insurance pay for prescriptions?_____YES_____NO

If your child does not have health insurance, would you like information on low/no cost health insurance?_____YES_____NO

***Parent or Guardian: Please provide your email address here:**

_____

	YES	NO		YES	NO
Is the child under medical treatment now?			Has the child ever been hospitalized for any surgical operations or serious illness?		
Is the child taking any medication(s) including non-prescription medications? If yes, what are you taking:_____			Does the child use tobacco?		
Does the child use alcohol, cocaine, other drugs?			Is the child wearing contact lenses?		
Is the child allergic to or has he or she had any reactions to the following: *Local anesthetics* *Penicillin or other antibiotics* *Sulfa Drugs* *Barbiturates* *Sedatives* *Iodine* *Aspirin* *Other: _____*			For females only: a) Is the child pregnant or do you think she may be pregnant? b) Is she nursing? c) Is she taking birth control pills?		

Does the child has he/she had any of the following?

	YES	NO		YES	NO		YES	NO
High blood pressure			Cardiac disease			Ulcers		
Heart attack			Heart Murmur			Chest pains		
Rheumatic fever			Hay Fever/allergies			Easily winded		
Swollen ankles			Frequently tired			Stroke		
Fainting/seizure			Recent weight loss			Angina		
Asthma			Emphysema			Tuberculosis		
Low blood sugar			Radiation therapy			Cancer		
STD			Arthritis			Glaucoma		
Leukemia			Joint Replacement			Anemia		
Diabetes			Joint Implant			Liver disease		
Kidney disease			Hepatitis/jaundice			Heart trouble		
AIDS or HIV infection			Epilepsy/convulsions			Thyroid problem		
Stomach trouble			Heart disease			Respiratory problems		

AUTHORIZATION AND RELEASE:

I certify that I have read, understand and have accurately answered all questions above. I understand that providing incorrect information can be dangerous to my child's health. I authorize Bienville Family Clinic to release any information including diagnostic records, and the records of any treatment or examination rendered to my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Bienville Family Clinic otherwise payable to me.

Signature of parent/guardian if student is a minor: _____ Date:_____
(PLEASE SIGN NAME HERE)

Parent-Guardian Name: _____
(PLEASE PRINT NAME HERE)

Parent-Guardian Address: _____
STREET CITY STATE ZIP CODE

Parent-Guardian **HOME** Phone _____ Parent-Guardian **CELL** Phone _____