Cabarrus Pediatrics

Child's Name	Birthday	M/F	Today's Date

Mother/ Legal Guardian Contact Information	***Father/Alternate Parent Contact Information***
Name(s)	Name(s)
Relationship	Relationship
Address	Address
Phone	Phone
Work/Cell Phone	Work/Cell Phone

Emergency Contact Information	*I hereby grant the following people (over 18 years of age) permission to bring my child to Cabarrus Pediatrics for medical care and I grant the following people the authority to make medical decisions regarding my child on my behalf:*
Name(s)	
Relationship	
Address	Name/Relationship
Phone	
Work/Cell Phone	Signature Date

Biological Family History

Relationship	*Name*	*Birthday*	*Health problems (or circle from list below*)*	*Living?*
Mother				*Yes/No*
Father				*Yes/No*
Brother/Sister				*Yes/No*
				Yes/No
				Yes/No
				Yes/No
				Yes/No
Maternal Grandmother *(mother's mother)*				*Yes/No*
Maternal Grandfather *(mother's father)*				*Yes/No*
Paternal Grandmother *(father's mother)*				*Yes/No*
Paternal Grandfather *(father's father)*				*Yes/No*

***Health problems** – *please circle and include relationship(s) to patient. Example: Asthma, paternal grandmother*

Heart disease/heart attack	High cholesterol	High blood pressure	Unexplained death (less than 50 years of age)	
Heart rhythm disorder	Stroke	Diabetes	Weight problems	Cancer
Allergies/eczema	Asthma/Lung disease/CF/TB	Immune/Infection disorder	Thyroid/Hormone disorder	Blood/Sickle Cell
Bone disorder/hip dysplasia	Gastrointestinal disorder	Kidney/Urinary disorder	Seizures/Epilepsy	Migraine
Psychiatric disorder	Mental delay	Birth Defects/Genetic problem	Other:	

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Social History

At home, patient lives with:

Parents are *(circle)*: Married Single Separated Divorced Other:

Smokers in/around the home: Yes/No	City or well water/Fluoride supplement	Guns: Yes/No

Pets:	Languages spoken in the home:

Birth History

Birth Weight: Length of pregnancy: Vaginal / C-Section Born at: CMC-NorthEast / Other

Complications in pregnancy/birth:

Reason for c-section (if needed): repeat / breech / other:

Medical History

Allergies (Drugs, food, insects, other) & type of reaction	Chronic Medications (Name and dose)

Past Surgeries, Medical Problems, Hospitalizations (include dates or age)

Any concern about how your child *(circle)*: *learns / communicates / understands / uses arms or legs / uses hands / interacts with others.*

Any history of the following *(circle):*		Weight concern	Growth concerns	Fatigue / weakness	Skin problems
Eye / vision problems	Frequent nose bleeds	Sinus infections	Many ear infections	Tubes in ears	Tonsils removed
Dental problems	Frequent sore throats	Swollen glands	Heart murmur	Passing out	Chest pain
Wheezing/asthma	Abdominal pain	Constipation/diarrhea	Vomiting/nausea	Excess thirst	Problems urinating
Swollen / painful joints	Frequent headaches	Seizures	ADHD	Behavior problems	Depression/anxiety
School trouble	Social problems	Chicken pox	Measles	Mumps	Rubella
Whooping cough	Pneumonia	Kidney infection/UTI	Meningitis	Other:	

Insurance Information

Health Insurance Plan:	Card Scanned? Y / N
Secondary Insurance:	Card Scanned? Y / N

Assignment of Insurance/Liability Benefits: I hereby authorize payment directly to Cabarrus Pediatrics (CP) and all physicians involved in my treatment or diagnosis at CP by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of treatment of the below named patient, I unconditionally assign any insurance benefits to CP and all physicians involved in my treatment and further authorize them to apply any surplus insurance benefits to any other payments received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to CP and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees, expenses and/or interest associated with collection of the debt.

I hereby authorize disclosure of the health information for the above named patient to the medical provider to whom I am being referred for medical care. This authorization is valid for 12 months from the date of signature. I understand that I may cancel the request with written notification but that will not effect any information released prior to notification.

Referrals and Authorizations: I realize that my physician may recommend that I receive additional treatment from a specialist, and that my insurance carrier may require that my primary care provider complete a referral and/or authorization for such treatment. I acknowledge that it is my responsibility to make sure the specialist has received the completed referral/authorization prior to my scheduled appointment with the specialist. If the referral/authorization is not completed prior to the visit, I will be required to pay for the visit in full at the time of service.

By signing this document I acknowledge that I have read, understood, and will comply with its content.

Signature ____ Date ____