Wesle

Carolinas Physicians Network
Carolinas HealthCare System
Patient Registration-Pediatric

ORG# _____

MRN# _____

	Patient	*Parent/Responsible Party- if different* Patient Relationship ☐ Parent ☐ Guardian
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Sex	☐ Male ☐ Female	
Child Lives With	☐ Mother ☐ Father ☐ Grandparent ☐ Guardian	

	Mother / Guardian	*Father / Guardian*
Date of Birth		
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

	Emergency Contact *(Other than Parent/Guardian)*	**Reason for visit** _____
Name		
Address		
Home Phone		Who referred you? _____
Work Phone		Permission to leave voice mail @ primary phone number? ☐ Yes ☐ No
Mobile Phone		

	Primary Insurance	**Secondary Insurance**
Insurance Company		
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	

Primary Care Physician _____ If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

Person responsible for payment of bill: ☐ **Mother** ☐ **Father** ☐ **Guardian or Other** _____

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

One patient per authorization form

There may be a charge for record copies.

Carolinas HealthCare System

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: ❑ Ongoing Communication ❑ Copy of Record ❑ Legal or Insurance Review ❑ Authorized Representative's Request ❑ Other _____

RELEASE FROM: The facility / practice / individual listed below is authorized to release the requested health information:

Facility/Practice Name: _____ **Telephone #:** _____

Facility/Practice Address: _____ **Fax #:** _____

The facility / practice / individual listed above is authorized to release the requested health information for the following: date(s) of service, range of time or event(s): **From:** (MM / DD / YY) _____ **To:** (MM / DD / YY) _____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ **All Records & Details**
❑ Appointment Information
❑ Billing Information
❑ Consultation Report
❑ Discharge Summary
❑ Emergency Room Records
❑ History & Physical
❑ Immunization Records
❑ Lab / Pathology Reports
❑ Medication Records
❑ Office / Clinic Notes
❑ Operative Report
❑ Physician's Orders
❑ Progress Notes
❑ Psychiatric Evaluation
❑ Radiology / Imaging Reports
❑ Test Results
❑ Other (Please Specify) _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ (First) _____ (Middle / Maiden) _____ (Last)

Patient Address: _____ (Street Address / PO Box, City, State, Zip)

Social Security #: _____ **Date of Birth:** _____ **Medical Record/Chart #** _____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ **Work:** _____ **Cell:** _____

RELEASE TO: This information may be released to and used by the following individuals / organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals / organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices / Policy.
- This authorization will expire when the information from the event / purpose noted above is released to the recipient named in this document.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____

SIGNATURE: _____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the information is relating to the treatment of pregnancy, drug and / or alcohol abuse, venereal disease, or emotional disturbance for a patient under the age of of 18, the patient must also sign this authorization.

NAME OF MINOR: _____ **SIGNATURE OF MINOR:** _____ **DATE:** _____

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No ❑ N / A

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient Date of release: _____ via ❑ Mail ❑ Fax ❑ Other _____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

Employee Name & Title _____

Employee Signature: _____ Date: _____

Wesley Chapel Family Medicine

Carolinas HealthCare System

Un Paciente Por Formulario de Autorización | Podría Haber un Costo por Copias de Historiales

Carolinas HealthCare System - Authorization for Release of Health Information Form

Carolinas HealthCare System – Formulario de Autorización para Dar a Conocer Información de Salud

Por medio del presente, autorizo el uso o la revelación de mi información de salud identificable como es descrito abajo. Entiendo que si la organización autorizada a recibir la información no es una compañía de seguro o un proveedor de salud, la información entregada podría ya no ser protegida por las regulaciones federales de privacidad.

PROPÓSITO DE LA ENTREGA: ❑Comunicación en Curso ❑Copia del Historial ❑Revisión Legal o del Seguro ❑Solicitación de un Representante Autorizado ❑ Otro _____

ENTREGA POR PARTE DE: La instalación/consultorio/individuo anotado abajo está autorizado a entregar la información de salud solicitada:

Nombre de la instalación/consultorio: _____ Número Telefónico _____

Dirección de la instalación/consultorio: _____ Número de Fax_____

La instalación/consultorio/individuo anotado arriba está autorizado a entregar la información de salud por lo siguiente: fecha(s) del servicio, margen de tiempo o evento(s): Desde:(mes/día/año) _____ Hasta:(mes/día/año) _____

MARQUE LA INFORMACIÓN ESPECÍFICA A SER ENTREGADA:

❑ Todos los Historiales y Detalles	❑ Resumen del Alta	❑ Reportes de Laboratorio/Patología	❑ Notas de Progreso	❑ Ordenes del Doctor
❑ Información de Citas	❑ Historiales de la Sala de Emergencia	❑ Registro de Medicamentos	❑ Evaluación Previa Psiquiátrica	❑ Otros (Por favor, especifíque) _____
❑ Información de Cobros	❑ Historial y Examen Físico	❑ Notas de Oficina/Clínica	❑ Radiología/Reportes de Imágenes	_____
❑ Reporte de la Consulta	❑ Registro de Vacunas	❑ Reporte Operatorio	❑ Resultados de Pruebas	_____

Entiendo que la información en mi historial médico puede incluir información relacionada a tratamiento de abuso de droga o alcohol, anemia de células falciformes, insuficiencia psicológica o psiquiátrica, enfermedades por transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA), complejo relacionado al SIDA y/o otros virus de la inmunodeficiencia humana (VIH).

NOMBRE DEL PACIENTE CUYA INFORMACIÓN SERÁ ENTREGADA:

Nombre del Paciente: _____ _____ _____
Primer Segundo/De Soltera Apellido

Dirección del Paciente: _____
(Dirección de Calle/Apdo. Postal, Ciudad, Estado, Código Postal)

Número de Seguro Social: _____Fecha de Nacimiento: _____ Número de Historial/Hoja Médica_____

Por favor, provea los números telefónicos donde usted está autorizando a CHS a dejar la información del paciente descrita arriba:

Casa: _____ Trabajo: _____ Celular: _____

ENTREGAR A: Esta información puede ser entregada a y usada por los siguientes individuos/organizaciones. Una autorización aparte debe ser completada si la información entregada o el propósito difieren entre los individuos/organizaciones anotados abajo:

Nombre	Dirección	Número Telefónico/Fax	Parentesco/Relación
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DERECHOS Y FIRMA DEL PACIENTE:

- Entiendo que tengo el derecho de revocar esta autorización en cualquier momento al notificar por escrito al Departamento de Registros Médicos ("Medical Record Department") de la organización mencionada arriba. (Entiendo que la revocación no se aplicará a la información que ya ha sido entregada en respuesta a esta autorización. Entiendo que una revocación no se aplicará a mi compañía de seguro cuando la ley le otorga el derecho de impugnar un reclamo bajo mi póliza.)
- Entiendo que autorizar la revelación de esta información de salud privada es voluntario y puedo rehusarme a firmar esta autorización.
- Entiendo, según el CHS Anuncio de Cómo Manejamos la Privacidad, que puedo solicitar inspeccionar u obtener una copia de la información a ser usada o revelada.
- Esta autorización se vencerá cuando la información del evento/propósito anotado arriba es entregada al destinatario nombrado en este documento.

Si el paciente es menor de edad o es incapaz clínicamente de firmar, un representante autorizado puede firmar esta autorización.

NOMBRE EN LETRA DE IMPRENTA (Paciente/Representante Autorizado): _____

FIRMA: _____ FECHA: _____

Si la firma es de un Representante Autorizado, por favor, indique su parentesco/relación: ❑ Esposo/a ❑ Padre/Madre ❑ Guardián ❑ Testamentario ❑ Apoderado

FIRMA DEL MENOR DE EDAD: Por favor, tome nota, si la información es relacionada al tratamiento de un embarazo, abuso de droga y/o alcohol, enfermedad venérea, o trastorno emocional para un paciente menor de 18 años de edad, el paciente debe también firmar esta autorización.

NOMBRE DEL MENOR: _____FIRMA DEL MENOR: _____ FECHA: _____

COMPENSACIÓN FINANCIERA: Si el solicitante de la información es un proveedor de cuidado de salud, ¿recibirá él alguna compensación financiera a cambio del uso o revelación de la información descrita arriba? ❑ Sí ❑ No ❑ No se aplica

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient / Date of release:_____via ❑Mail ❑Fax ❑Other_____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

CHS Employee Name & Title: _____CHS Employee Signature: _____Date _____

Carolinas Physicians Network

ACKNOWLEDGEMENT FORM

Medical Records # _____

Patient's Name: _____ Date of Birth _____/_____/_____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature:_____ Date: _____
(Patient or Authorized Representative)

Relationship to Patient: _____ Self _____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

_____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico _____

Nombre del Paciente _____ Fecha de Nacimiento _____/_____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representante Autorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Firmar:_____

Carolinas Physicians Network

Carolinas HealthCare System

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Carolinas Physicians Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co-pays, deductibles & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

MEDICARE PLANS are more numerous and complicated. Carolinas HealthCare System and Carolinas Physicians Network participate with **Traditional Medicare (Part A & Part B)** and a limited number of Private Fee-for-Service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for-Service Plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare and a limited number of PFFS, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co-pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

OTHER INSURANCES are those plans we do not participate in. You may be responsible for payment in full at the time of service. As a courtesy, we will file your claim.

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

MEDICAID may not be accepted by your provider. Please check with your provider's office before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Identification Card to each visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF PAY PATIENTS are those patients who **do not have insurance coverage.** Self pay patients will be given a 25% discount off the charges for services provided and are expected to pay a minimum of $50.00 at the time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL FORMS/MEDICAL LEAVE/DISABILITY FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient/Guardian Name _____

Patient/Guardian
Signature _____ Date _____

How Did You Hear About Us?

Thank you for choosing the physician practices of Carolinas Physicians Network. We would appreciate you taking the time to complete this form.

Please select one of the following:

Did you hear about us in one of the following ways:

Community Seminar/Event	Where/When: _____
Mail	_____
Newspaper Advertisement	Publication: _____
Patient Resource Center Brochure	_____
Radio Advertisement	Station: _____
Saw the Facility	_____
Social Services	_____
Television Advertisement	Station: _____
Web site	_____
Yellow Pages	_____
Other	_____

Whom may we thank for referring you to our practice?

Carolinas HealthCare System Employee	Name: _____
Employer	Name: _____
Friend	Name: _____
Insurance Provider	Name: _____
Physician Referral	Name: _____
Relative	Name: _____

Your Name: _____

Carolinas Physicians Network
Carolinas HealthCare System

SPORT PREPARTICIPATION HISTORY FORM

FORM CURRENTLY RECOMMENDED BY NCMS SPORTS MEDICINE COMMITTEE (7/93)

Patient's Name: _____ Age: _____

Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

Physician's Directions: We recommend repeating the thirteen questions listed below and carefully reviewing details of any positive answers.

YES	NO	DON'T KNOW		
			1.	Has anyone in the athlete's family (grandmother, grandfather, mother, father, brother, sister) died suddenly before the age of 50?
			2a.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
			2b.	Have you ever been told you have a heart murmur or heart problems?
			3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
			4.	Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint?
			5.	Does the athlete have a history of concussion (getting knocked out)?
			6.	Has the athlete ever suffered a heat-related illness (heat stroke or heat exhaustion)?
			7.	Does the athlete have anything he/she wants to talk to the doctor about?
			8.	Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
			9.	Does the athlete take any medicine?
			10.	Is the athlete allergic to any medications or bee stings?
			11.	Does the athlete have only one of any paired organ? (eyes, ears, kidneys, testicles, ovaries, etc.)?
			12.	Do you wear contacts or eye glasses?
			13.	Date of last tetanus booster. DATE:

Elaborate on any positive answers:

I have answered and reviewed the questions above and give permission for my child to participate in sports.

Signature of Parent or Guardian: _____

Address: _____

Date _____ Phone # _____

EXAMINATION

PATIENT'S NAME: _____

*1. BP_____ WT_____ HT_____ VISION (R)_____(L)_____

*2. Cardiovascular Exam _____ Normal _____ Abnormal Comments:
Murmur _____ Yes _____ No Describe:

*3. Musculoskeletal Exam Record laxity, weakness, instability, decreased ROM-if abnormal

Knee _____ Normal _____ Abnormal
Ankle _____ Normal _____ Abnormal
Shoulder _____ Normal _____ Abnormal
Other Orthopedic _____ Normal _____ Abnormal
Problems, e.g. neck, feet, scoliosis)

4. Optional Exam should be done if history is positive. Comments:

ENT _____ Normal _____ Abnormal
Chest _____ Normal _____ Abnormal
Abdomen _____ Normal _____ Abnormal
Genitalia _____ Normal _____ Abnormal
Skin _____ Normal _____ Abnormal

*ASSESSMENT: 5.A. _____ No problems identified 5.B. Other:

*RECOMMENDATIONS:
6.A. ____ Unlimited B. ____ Limited to specific sports C. ____ Deferred until (e.g., rehab., recheck, consultation, lab, etc.)

*RE-EXAMINE: 7.A. ____ Yearly and after any injury that limits participation for greater than one week
B. ____ Other:

REQUIRED ELEMENTS ARE IN ASTERISK

I certify that I have examined the above student and that such examination revealed (_____ conditions _____no conditions) that would prevent this student from participation in interscholastic sports.

Are you licensed to practice medicine in the United States? _____ Yes _____ No

Signature _____ Phone Number _____

Address _____ Date _____

_____

If student is not qualified, list reasons for disqualification: _____

_____

(The following are considered disqualifying until medical and parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, testicle or ovary, etc.)

12/99

Children's Medical Report

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent of Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, what?_____

_____

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason?_____

_____

3. Is the child on any continuous medication? No___ Yes___ If yes, what?_____

_____

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what?_____

_____

5. Any history of significant previous diseases or recurrent illness? No___ Yes___ ;
   diabetes No___Yes___; convulsions No___ Yes___; heart trouble No___ Yes___.
   If others, what/when?_____

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe:_____

_____

Any mental disabilities? No___ Yes___ If yes, please describe:_____

Signature of Parent or Guardian _____ **Date** _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____

Throat_____ Neck_____ Heart_____ Chest_____ Abd/GU_____

Ext_____ Neurological System_____ Skin_____

Results of Tuberculin Test, if given: Type_____ date_____ Normal___ Abnormal_____

Should activities be limited? No___ Yes___ If yes, explain: _____

Any other recommendations: _____

_____ Date of

_____ Examination_____

Signature of authorized examiner/title _____ **Phone #** _____

Wesley Chapel Family Medicine
Carolinas HealthCare System

Minor/Child Registration Form

Pt. Name: _____

Date Completed: _____

BIRTH HISTORY

Hospital _____ Obstetrician _____

Type of delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Weight _____

Did baby have any problems at or immediately after birth? _____

List Age Cooed or Laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toilet Trained _____

FAMILY HISTORY

HAS ANY MEMBER OF THE FAMILY OR CLOSE RELATIVE HAD:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Chemical Dependency	☐	☐	Heart Disease	☐	☐	Kidney Disease	☐	☐	Tuberculosis
☐	☐	Asthma or Hay Fever	☐	☐	Convulsion or Epilepsy	☐	☐	Hemophilia - Bleeder	☐	☐	Mental Disorders	☐	☐	Other
☐	☐	Cancer	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Migraine			

HEALTH HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now? _____	☐	☐
Receiving any medication or drugs? _____	☐	☐
Has your child been hospitalized? _____	☐	☐

Medications _____

Date Reason Hospital

_____

_____

Allergies _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Cerebral Palsy	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Speech Problems
☐	☐	Anemia	☐	☐	Chicken Pox	☐	☐	Fainting	☐	☐	Measles	☐	☐	Thyroid Disease
☐	☐	Bed Wetting	☐	☐	Constipation, Diarrhea	☐	☐	Hearing Problems	☐	☐	Mononucleosis	☐	☐	Tuberculosis
☐	☐	Birth Defects	☐	☐	Convulsions	☐	☐	Heart Problems	☐	☐	Mumps	☐	☐	Urinary Disease
☐	☐	Bladder Problems	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Pneumonia	☐	☐	Vision Problems
☐	☐	Bleeding, Excessive	☐	☐	Drug/Alcohol Abuse	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever	☐	☐	Worms
☐	☐	Cancer	☐	☐	Ear Infections	☐	☐	Lead Poisoning	☐	☐	Sinus Problems	☐	☐	Other

DEVELOPMENTAL & SOCIAL HISTORY

Who lives with this child? Please List: _____

YES	NO		YES	NO	
☐	☐	Are both parents involved in the child's life?	☐	☐	Do you have concerns about the child's development?
☐	☐	Is the child in day care or after school program?			Please List: _____
☐	☐	Does anyone smoke in the home?	☐	☐	Do you have issues about the child's problems in school?
☐	☐	Is there a second language used at home?			Please List: _____
		Please List: _____	☐	☐	Does your child participate in sports, church or community activities?

RELEASE

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

_____ _____

Signature of Parent/Guardian Date