NEW PATIENT PEDIATRIC FORM

DATE______________________

NAME ____ MALE FEMALE

ADDRESS _________________________________CITY/STATE _______________ ZIP CODE ___________

AGE ________ DATE OF BIRTH _______________

NAME OF FATHER ____________________________NAME OF MOTHER _____________________________

HOME PHONE # ______________________ CELL PHONE # _______________________

LEGAL GUARDIAN (IF OTHER THAN PARENT) ______________________________

HOME PHONE #_______________________CELL PHONE #________________________

HEALTH INSURANCE COMPANY NAME (IF APPLICABLE) ___________________________________

POLICY #______________________________GROUP #__________________________

HEALTH INSURANCE PHONE #____________________________

INSURED'S NAME: _________________________ RELATIONSHIP TO PATIENT: ________________________

INSURED'S DATE OF BIRTH______________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ WEBSITE ☐ PHONE BOOK ☐ REFERRAL____________________________

WHAT IS THE REASON YOUR CHILD IS HERE TODAY? ____

____

HOW LONG HAS YOUR CHILD HAD THIS? ____

HAS HE/SHE BEEN SEEN BY ANOTHER DOCTOR? DIAGNOSIS? TREATMENT?____________________________

____

____

HAVE THEIR BEEN OTHER TREATMENTS ATTEMPTED TO IMPROVE THIS CONDITION?______________________

____

HAS YOUR CHILD EVER HAD SIMILAR CONDITIONS IN THE PAST? ____________________________________

THIS CONDITION IS ☐ GETTING WORSE ☐ STAYING THE SAME ☐ IMPROVING

DOES ANYTHING AGGRAVATE THIS CONDITION?____

DOES ANYTHING IMPROVE THIS CONDITION?____

OTHER THAN TODAY'S PRESENTING COMPLAINT, PLEASE LIST ANY AND ALL CONCERNS REGARDING YOUR CHILD'S OVERALL HEALTH____

____

____

BIRTH HISTORY

DELIVERY METHOD: (PLEASE CHECK ALL THAT APPLY)

☐ VAGINAL ☐ FORCEPS ☐ VACUUM EXTRACTION ☐ CAESAREAN SECTION

ANY COMPLICATIONS DURING THE PREGNANCY OR WITH THE DELIVERY? ________________________________

____

ANY KNOWN CONGENITAL ANOMALIES / DEFECTS? ____

PAST HEALTH INFORMATION

PEDIATRICIAN'S NAME______________________________ DATE OF LAST VISIT __________________________

PLEASE DESCRIBE THE REASON FOR LAST VISIT:____

HAS YOUR CHILD HAD ANY MAJOR INJURIES, FALLS, HEAD INJURIES, OR ACCIDENTS? ☐ NO ☐ YES

APPROXIMATE DATE:_____________ DESCRIBE INCIDENT:____

____

APPROXIMATE DATE:_____________ DESCRIBE INCIDENT:____

____

HAS YOUR CHILD HAD ANY SURGICAL OPERATIONS OR BEEN HOSPITALIZED? ☐ NO ☐ YES

APPROXIMATE DATE:_____________ DESCRIBE:____

____

HAS YOUR CHILD HAD ANY SURGICAL OPERATIONS OR BEEN HOSPITALIZED? ☐ NO ☐ YES

APPROXIMATE DATE:_____________ DESCRIBE:____

____

PLEASE PROVIDE THE TYPES OF FOOD/DRINK CONSUMED ON AN AVERAGE DAY:

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK

PLEASE LIST NUTRITIONAL SUPPLEMENTS, OVER-THE-COUNTER MEDICATIONS, OR PRESCRIPTION MEDICATIONS TAKEN BY THIS CHILD:

NAME	**DOSAGE**	**FREQUENCY**	**HOW LONG?**	**REASON**

THIS TABLE CONTINUES ON THE NEXT PAGE

(Medication/Supplementation continued)

Name	Dosage	Frequency	How long?	Reason

Review of Health Systems

Has your child ever suffered from: (Check all that apply)

General

___Headaches/Migraines
___Convulsions/Epilepsy
___Tremors
___Loss of Balance
___Dizziness/Vertigo
___Fainting
___Sleeping Problems
___Colic
___Cold Sweats
___Weight Problems
___Loss or gain of a significant amount weight within 6 months
___Jaw/TMJ Problems
___Ruptures/hernias
___Developmental delays

Serious Illnesses/Diseases

___Chicken Pox (Age:____)
___Measles (Age:____)
___Mumps (Age:____)
___Rubella (Age:____)
___Whooping Cough (Age:____)
___Rubeola (Age:____)
___HIV/AIDS (Age:____)
___Cancer (Age:____, Type:_________)
___Thyroid Problems
___Liver Trouble/Hepatitis
___Kidney Problems
___Diabetes Type I or II
___Other:______________ (Age:____)

Emotional/ Mental

___Nervousness/Anxiety
___Unexplained Fatigue
___Depression
___Irritability/Mood Swings
___Tension/Stress
___Behavioral Issues
___Hyperactivity

Integumentary System

___Skin Problems
___Rashes
___Hives
___Skin Sensitivity
___Easy Bruising

Ears, Eyes, Nose, Throat

___Frequent Colds/Flu
___Blurred Vision R/L
___Double Vision R/L
___Ear Infection
___Loss of Smell
___Buzzing/Ringing in ears
___Sinus Problems/Allergies
___Allergies
___Recurrent Ear Infections
___Tooth Abscess
___Difficulty Hearing

Musculoskeletal System

___"Growing" Pains
___Neck Stiffness/Pain
___Mid-Back/Rib Stiffness/Pain
___Low Back Stiffness/Pain
___Hip Pain R/L
___Fractured Bones
___Swollen Painful Joints
___Muscle Problems
___Difficulty Walking
___Scoliosis
___Shoulder/Elbow Problems
___Wrist/Hand Problems
___Knee/Ankle/Foot Problems

Gastro-Intestinal System

___Gall Bladder Problems
___Digestive Problems
___Stomach Upset
___Heartburn/Reflux
___Diarrhea/Constipation/Gas
___Poor appetite
___Food allergies or intolerances

GENITO-URINARY SYSTEM
__RECURRING INFECTIONS
__DIFFICULTY URINATING
__BED WETTING

CARDIOVASCULAR SYSTEM
__DIABETES TYPE I OR II
__HIGH BLOOD PRESSURE
__CHEST PAIN
__HEART PROBLEMS
__ ANEMIA

RESPIRATORY SYSTEM
__ASTHMA
__CHRONIC COUGH/COLD
__DIFFICULTY BREATHING
__PAIN W/COUGH / SNEEZE
__SHORTNESS OF BREATH
__LUNG PROBLEMS
__RECURRING INFECTIONS
__SINUS PROBLEMS

NERVOUS SYSTEM
__NUMBNESS/TINGLING/PAIN IN (ARM/HANDS/FINGERS)
__NUMBNESS/TINGLING/PAIN IN (BUTTOCKS/THIGHS/LEGS/FEET/TOES)
__COLD HANDS

REPRODUCTIVE SYSTEM
__URINARY TRACT INFECTIONS
__PELVIC PAIN

FEMALES:
__MENSTRUAL CRAMPING
__MENSTRUAL IRREGULARITY
__VAGINAL PAIN/INFECTION
__BREAST PAIN/LUMPS
AGE OF FIRST MENSTRUAL PERIOD:
____
DATE OF LAST MENSTRUAL PERIOD:
____
IS THERE ANY CHANCE THE PATIENT MIGHT BE PREGNANT?
_____YES _____NO _____ NOT SURE

AUTHORIZATION AND RELEASE: I, THE UNDERSIGNED, CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT MY INSURANCE COMPANY PAYS THEM. I HEREBY AUTHORIZE HUMBLE WELLNESS TO RELEASE ANY AND ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I ALSO ACCEPT THE RESPONSIBILITY FOR ANY FEES ASSOCIATED WITH PROVIDING SUCH INFORMATION TO MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY SCHEDULE OF CARE AS DETERMINED BY MY TREATING DOCTOR, ANY FEES FOR PROFESSIONAL SERVICES WILL BE IMMEDIATELY DUE AND PAYABLE.

OUR OFFICE DOES RESERVE THE RIGHT TO CHARGE FOR CANCELLATION WITH LESS THAN 24 HOURS NOTICE AND BROKEN APPOINTMENTS. WE ALSO RESERVE THE RIGHT TO RETAIN AN ACTIVE CREDIT CARD ON HAND FOR SECURING RESERVED APPOINTMENTS.

THE PATIENT UNDERSTANDS AND AGREES TO ALLOW HUMBLE WELLNESS TO USE THEIR PATIENT HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, AND COORDINATION OF CARE. WE WANT YOU TO KNOW HOW YOUR PATIENT HEALTH INFORMATION IS GOING TO BE USED IN THIS OFFICE AND YOUR RIGHTS CONCERNING THOSE RECORDS. IF YOU WOULD LIKE TO HAVE A MORE DETAILED ACCOUNT OF OUR POLICIES AND PROCEDURES CONCERNING THE PRIVACY OF YOUR PATIENT HEALTH INFORMATION, WE ENCOURAGE YOU TO READ THE HIPAA NOTICE ENTITLED *NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION* THAT IS AVAILABLE TO YOU AT THE FRONT DESK BEFORE SIGNING THIS CONSENT. IF THERE IS ANYONE YOU DO NOT WANT TO RECEIVE YOUR MEDICAL RECORDS, PLEASE INFORM US.

I UNDERSTAND AND HAVE BEEN PROVIDED WITH A *NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION,* IF REQUESTED, THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS AND PRIVILEGES:

- THE RIGHT TO REVIEW THE NOTICE PRIOR TO SIGNING THIS CONSENT,
- THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES, AND
- THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

PATIENT / GUARDIAN SIGNATURE ____ DATE ________________