



Patient Information					
Patients Name		DOB	_		
SS #	Age	Gender: Male / Female			
Siblings Name					
Home Address			-		
City / State / Zip			_		
		ternate Phone #	_		
May we leave confidential messag	ges at the numbers listed above?	?	_		
	<u>Insurance I</u>	Information			
Grantor Name	DOB _	SS #			
Primary Insurance:		IDGrp	_		
Grantor Name	DOB _	SS #	_		
Secondary Insurance		IDGrp			
Parent Information					
	D	OOB SS#			
Birth/Step/Adoptive/Foster Email Address		Primary #	_		
Home Address (if different)					
Occupation		Phone #			
Father/Parent	D	OOB SS#			
Birth/Step/Adoptive/Foster Email Address		Primary #			
Home Address (if different)			_		
Occupation		Phone #	_		

#### **Emergency Contact/Additional Persons**

Please list all emergency contacts and/or persons who may have permission to bring the patient in for medical care and sign consent for any vaccine administration.

Name	Authorized to bring patient	Phone Number	Relationship to Child
	Yes/No		
	Yes/No		
	Yes/No		

Signature	Date



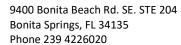
## **Patient Medical History**

Pregnancy & Birth Information					
other's age at birth? Medication during pregnanc	/? Yes No <b>Excl</b>	ude Vitamins/Iron			
y problems during pregnancy? Excessive Weight Gain_ her(please explain)			Venerea	al Disease	
ring pregnancy did Mom? Smoke Consume Alcoho	Street Drugs				
birth, how many gestational weeks was your child?	Type of delivery? \	/aginal/C-Section			
_		_			
th Weight Birth Length	Birth Head Circ	umference			
d baby have any complications at birth? Breathing: Yes	No laundico:	Vos No			
baby have any complications at bilting breathing. Tes	NO Jaunuice.	res No			
oblems after birth?					
oding? Proact Milk Formula Formula Type					
eding? Breast Milk Formula Formula Type					
eding Problems? Colic Recurrent Vomiting Re	current Diarrhea	_ Multiple Formula Chan	ges	-	
Has our child	ever had any of the	e following?			
o Measles o Mumps	0	Chicken Pox	0	Whooping Cough	
o Scarlet Fever o Ear Infection	ons o	Asthma/Wheezing	0	Eczema/Hives	
o Anemia o Hepatitis	0	Seizures	0	Urinary Infections	
o Blood Transfusions o Joint Probl	ems o	German Measles	0	Bleeding Tendence	
o Problems Hearing o Problems v	vith Vision o	Strep Throat	0	Other	

# List all blood relatives of your child who have had the following medical problems using the abbreviations listed below: (F) Father (M) Mother (S) Sister (MM) Mother's Mother (MF) Mother's Father (FM) Father's Mother (FF) Father's Father (A) Aunt (U) Uncle (C) Cousin

Anemia/Blood Disorder	Allergies	Alcoholism	Arthritis	AIDS/HIV
Asthma	Allery Shots	Cancer	Cystic Fibrosis	Cholesterol Problem
Birth Defects	Diabetes	Eczema	Ear Tubes	Epilepsy/Seizures
Drug Problem	Early Deafness	Emotional/Behavioral	Growth Problems	Heart Attack/Stroke
Heart Disease	High Blood Pressure	Hereditary Problems	Mental Retardation	Muscular Dystrophy
Migraines	Tuberculosis	School Problems	Sudden Infant Death	Other

Signature	Date
•	

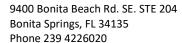




## **Acknowledgement of Receipt of Notice of Privacy Practice**

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this office's Notice of Privacy Practices, w and disclosed. I understand that I am entitled to receive a (patient representative, initial one only)	
I reviewed a copy of the Notice of Privacy Practices an	d have declined a copy.
I reviewed and received a copy of the Notice of Privac	y Practice.
Name of Patient (Please Print)	
Name of Patient Representative (Please Print)	-
Signature of Patient, or Patient Representative (Representative required If the patient Is a minor or an adult unable to s	- sign this form)
<u>Financial Re</u>	<u>esponsibility</u>
ASSUMPTION OF FINA	NCIAL RESPONSIBILITY:
I understand that I am financially responsible to the whether covered by my insurance company or not. Trendered unless submitted to an insurance company contract.	These charges are to be paid at the time services are
I also understand that non-covered services under modernment become my full responsibility. This may include copa outside my child's growth and development during a	ays and/or charges incurred for any issue discussed
In the event collections proceedings are instituted to Group, I, the undersigned, agree to pay the addition attorney fees, plus all associated court fees.	
Please be advised an after-hour charge may apply fo	or appointments after 5pm and on the weekends.
Name of Patient Representative (Print Name) (Representative required If the patient Is a minor or an adult unable to see the second sec	sign this form)
Signature	Date





### **Office Policies**

- Our office does accept walk-in appointments for established/current sick patients upon availability. Please be advised that scheduled appointments will be seen accordingly.
- Our office may terminate a patient after 3 (three) consecutive "no-show" appointments. When canceling please call 24 hours in advance.
- Our office will allow a scheduled patient to arrive up to 5 minutes late. After that you
  may be required to reschedule your appointment depending on the nature of the visit
  and/or the availability of the provider you are seeing.
- A parent/guardian choosing to decline vaccinations must sign a "Refusal to Vaccinate" form in order to continue services with our clinic. We reserve the right to dismiss any patients refusing to comply.
- We accept the following forms of payments, which are due at the time of service: Cash, Debit/Credit Cards, Checks.
- Please be advised that any issues discussed outside growth and development during a
  patient's well check must be charted by a provider and may result in a copay and/or
  additional charges.
- Our office reserves the right to dismiss a patient/patient's family from our practice for making unsubstantiated defamatory statements, whether written or spoken.
- If you are dissatisfied with our services, we take it seriously and invite you to contact our office to resolve the matter and aid us in improving those services.

Signature of Patient, or Pa			
(Representative required if the patient	is a minor or an adult unable to sign this form)		
	OFFICE USE ONLY:		
Witness Name:			
Signature:			
Date:			
Signature		Date	