BIRTH TO 5 YEARS

Date:_____ NAME: _____ DOB:_____

Pharmacy:_____

Please Circle One:

Primary Language in home: English Spanish Other

Ethnicity: Not hispanic or Latino Hispanic or Latino

Race: White Asian Native Hawaiian/Pacific Islander Black/African American 2 or more races Prefer not to answer

Are you interested in receiving your lab and test results electronically in the future? Yes No

Email address: _____

Patient's Past Medical History

Prior Testing/Developmental Test	None	Yes	Test: _____
Allergies	No	Yes	
History of Chicken Pox	No	Yes	Date: _____
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Ear disorder	No	Yes	
Eye disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth, Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
GI Disorder	No	Yes	
GU/ Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric/Learning Disorder	No	Yes	
Respiratory Disease/Asthma	No	Yes	
Skin Disease	No	Yes	
History of injury/trauma	No	Yes	Details:
Other Chronic problems			

Family Medical History

Please List Family Member and details below

Bleeding disorder		No	Yes
Cancer		No	Yes
Diabetes		No	Yes
Congenital heart disease		No	Yes
Heart disease before age 50		No	Yes
Eye disorder		No	Yes
Ear disorder		No	Yes
Respiratory disorder		No	Yes
GI disorder		No	Yes
GU disorder		No	Yes
Musculoskeletal disorders		No	Yes
Neurologic disorder		No	Yes
Psychiatric disorder		No	Yes
SIDS		No	Yes
Skin disease		No	Yes
Other			

Birth History

Birth weight			
Discharge weight			
Length			
Head circumference			
Gestational age	Full Term		Weeks:
Birth Location/Hospital			
Type of delivery/complications	None		
Birth complications	None		
Apgar Scores			
Oxygen at birth	Yes	No	
NICU Stay	Yes	No	How Long:
Synagis prophylaxis given in hospital	Yes	No	
Hep B given at birth	Yes	No	
Mother's pregnancy health	Normal		

Newborn Screening Test

Newborn Hearing Test	NL	ABN	Not Performed
Newborn State Screen	NL	ABN	Not Performed
Other Newborn Screening Test	NL	ABN	Not Performed

Surgical/Hospitalization History

			Details
Non-Surgical hospitalizations	None	Yes	
Surgical History	None	Yes	
Ear Surgery	None	Yes	
Eye Surgery	None	Yes	
Nose/Mouth/Throat Surgery	None	Yes	
Cardiovasular Surgery	None	Yes	
GI Surgery	None	Yes	
GU Surgery	None	Yes	
Eye Surgery	None	Yes	
Orthopedic Sugery	None	Yes	
Other Surgery	None	Yes	

Child Social History

Parent information: *(circle all that apply)*

Parents together	Father involved
Lives w/mother	Mother involved
Lives w/father	Father not involved
Guardian parents	Mother not involved
Same sex partners	Mother / Father deceased

Child care: Name of Daycare: _____

Home occupants (list all): _____

Parents smokers: (Circle one)

No Yes Outside only Yes

Pets, what kind, how many, inside or outside? _____

Extracurricular activities: (sports, music, etc.) _____

Pediatric Health History Form

CHILD'S NAME:_____ **DATE OF BIRTH**_____**AGE**____

PREVIOUS HEALTH CARE PROVIDER

_____

PRESENT HEALTH CONCERNS: _____

CURRENT MEDICATIONS/VITAMINS _____

HERBS/HOME REMEDIES _____

ALLERGIES.REACTIONS TO MEDICATIONS OR VACCINES _____

_____

PREGNANCY AND BIRTH

Where was your child born?_____

The child is yours by: Birth Adoption Stepchild Other_____

Please indicate any medical problems during pregnancy: None or Specify _____

_____

Delivered by: Vaginal Caesarean If caesarean, why? _____

_____

Birth weight_____Birth length_____ APGAR score 1 min_____5min_____

Please indicate any medical problems during the baby's newborn period: None

_____

Premature? If so, how many weeks? _____

NUTRITION AND FEEDING

Was/Is your child breast fed? No Yes if so, how long? _____

Has your child had any feeding or dietary problems? No Yes if so, specify _____

_____

Milk intake now: Type: Cows milk (nonfat 1% fat 2% fat whole milk) Soy milk, Rice milk

Average ounces per day (Note, 8 ounces = 1 cup) _____

SLEEP

Hours per night _____Naps (number and length)_____

Any sleep problems? _____

DEVELOPMENT

At what age did your child: Sit alone _____walk alone_____say words_____

Toilet train (daytime) _____

Females only: Age at first menstrual period _____

DENTAL HISTORY

Has your child seen a dentist? No Yes, how often? _____ date of last exam _____

Water source: City or well?

IMMUNIZATIONS/INFECTIOUS DISEASES: Please make sure we have a current record of previous records

Has your child had: Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB) None

EXPOSURES/HABITS: Any concerns about lead exposure? (Old home/plumbing/peeling paint)

No Yes

Do any household members smoke? No Yes

TV hours per day _____ Computers/Ipads/electronics hours per day_____

Video games hours per day _____

PAST MEDICAL HITSTORY

Please describe any major medical problems and their dates:

_____

_____

Hospitalization/operations with dates _____

_____

Broken bones or severe sprains? None Yes, specify _____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling,grandparent, aunt or uncle) with any of the following:

Alcoholism	High Cholesterol
Cancer, specify	High Blood Pressure
Heart Attack	Stroke
Depression/Suicide	Other
Diabetes	Other

SOCIAL HISTORY

Who lives at home?

Name Age Relationship highest education level

_____

_____

_____

_____

Are your child's parents Married Unmarried Separated Divorced

If divorced or separated, when? _____

Mother's occupation _____ Employer_____

Father's occupation_____ Employer_____

Child care situation Parent's Others (specify who and hours per day)_____

Concern's about your child? Alcohol use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern? No Yes

Are there guns in the home? No Yes

SCHOOL HISTORY:

Does your child attend school or preschool? No Yes

Current grade_____ Name of school_____

Any concerns about school performance? _____

Any concerns about relationship with teachers? No Yes

Students? No Yes

If more than 4 years old, does your child have a best friend? No Yes

Sports/Exercise: Type_____How often? _____How long ?(minutes)_____

REVIEW OF SYMPTOMS: Please check any current problems your child has on the list below.

Fevers/chills/excessive sweating	Cough/Wheeze
Unexplained weight gain/loss	Chest pain
Eyes: Squinting/closed eyes	Nausea/vomiting/diarrhea
Ears/Nose/Throat: Unusually loud voice/hard of hearing	Constipation
Mouth breathing/snoring	Blood in stool
Bad breath	Bedwetting
Frequent runny nose	Pain with urination
Problems with teeth or gums	Discharge from penis or vagina
muscle or joint pain	Rashes or unusual moles
Tired easily with exercise	Hay fever, itchy eyes
Shortness of breath	Headaches
Fainting	Weakness or clumsiness
Speech problems	Anxiety/stress
Sleep/nightmares	Depression
Nail biting/thumb sucking	bad temper, breath holding, jealousy
Unexplained lumps	Easy bruising/ bleeding

SAFETY

When your child is in the car does he use: An infant seat a booster seat a seat belt only

Do you have smoke detectors at home? No Yes

Does your child wear a helmet for a bike, scooter, ATV, etc.. No Yes

CONSENT TO TREAT

Permission is hereby given for patient _____, Date of birth_____ to receive any medical/surgical procedures, x-rays, drug or laboratory tests, medication or exam as may be deemed necessary by the physicians. In case of a minor, the consent below is given on his or her behalf.

Please initial:

_____ I hereby authorize Cumming Pediatric Group, PC to obtain medical records from any other physician or medical facility necessary in the course of my child's treatment

_____ By signing this document, I acknowledge I have received and read the Cumming Pediatric Group, PC Notice of Privacy Practices and Individual Rights

_____ I hereby authorize messages to be left on a voicemail system or patient portal concerning my child. I also give permission for my child's records to be released to me through the CPG patient portal.

Parent/Legal Guardian (Print Name)_____

Parent/Legal Guardian (Signature)_____ Date:_____

Cumming Pediatric Group

***Please initial each section indicating that you have read and understood our financial policy agreement.**

Insurance Coverage

You must provide your insurance card or proof of insurance at the time of each visit. If you do not have your insurance, are unable to provide proof of insurance, or on a plan which we do not participate with, full payment is required at the time of your visit.

It is very important that you become familiar with your insurance plan and understand its benefits. Some plans have restrictions on certain services and procedures that may not be covered in office. It is your responsibility to be aware of these restrictions. If you have questions regarding your coverage and payment determination, then you need to contact your insurance company directly.

All co-payments, deductibles, and co-insurance fees are your responsibility. If certain procedures and services are not covered by your insurance, you are personally responsible for these services. You will also be responsible for all balances your insurance carrier does not pay with in 90 days.

If you are self pay, you must pay in full at the time of service. We do offer a 25% discount.

_____(initial)

Payment Methods

All co-payments are due at time of service. These fees cannot be waived. For your convenience, we accept cash, checks, HAS/FSA cards, and all major credit cards.

**Please note, If you have a returned check, you may be charged a return check fee. Any unpaid balances may be sent to our collection agency.

_____(initial)

Referrals

If you are being referred to a specialist and your plan requires a referral, you are responsible for requesting the referral. The physicians may verbally refer you, but no hard copy will be sent without your request. Once services are rendered and a referral has been done, you are responsible for any fees not paid by your insurance company.

_____(initial)

Missed Appointments / Canceling Appointments

Missed appointments seriously disrupt the practice and inconvenience our patients. Therefore, please call to cancel your appointment before the visit is missed. If you fail to show for an appointment, our policy requires that we charge a $25 fee by our billing department. If you accumulate multiple missed appointments without cancelation, you may be dismissed from the practice.

_____(initial)

Delinquent Accounts

A payment plan can be arranged with our billing department for past due amounts. Failure to pay or arrange payment of a past due amount will result in a referral to our collection agency. **A 25% fee is added to your total balance owed if your account is sent to collections.** In order to re-establish good standing with our practice, your past due balance will need to be paid in full in order to be re-established. Your records may not be released until unpaid balances have been satisfied.

_____(initial)

Medical Record Requests

If you are requesting medical records to be sent to a specialist, there is no charge and we will forward them to the specialty physician as a courtesy. If you are transferring to another practice to continue care, we will send your records to you via our web portal, or to the new physician free of charge. If you want to pick up a full set of medical records there will be an $18 fee for one child, or $28 for a family.

_____(initial)

The original copy of this financial policy will be kept on file for future reference. If you would like a copy for your records, please as the front desk to provide you with a copy.

Parent/Guardian Consent Form

This form authorizes the following persons to bring my child to Cumming Pediatric Group for treatment. I am aware that these visits may include vaccinations, medications, referrals, labs or radiology services.

Patient name and date of birth

_____ _____/_____/_____

The following persons have my permission to bring my child to CPG

Name/Relation _____

Name/Relation _____

Name/Relation _____

Name/Relation _____

Parent/legal guardian signature _____

Date _____/_____/_____

HIPAA
Patient Confidentiality Notice

- Our practice is dedicated to maintaining the privacy of your child's health information. We are required by law to provide you with the notice of our policies that effect the information.

- we will use the data and information we collect to treat your child and will supply this information to those that are helping us diagnose and treat the patient.

- We will disclose this information to your health insurer and others who are responsible for payment of services that are rendered.

- We will disclose the patient's Protected Health Information (PHI) in the conduct of the business of this practice and as required by law to public health organizations, police, and law agencies.

- We will disclose you PHI to family members involved in your child's care, unless instructed not to do so.

- You have the right to request that we handle your PHI in a particular manner, such as instructing us to call your home rather than work, or requesting that we only speak to certain persons about your child's health. To request confidential communication, ask for more information at the front desk. You do not have to give us reason for this request.

- Patients have the right to inspect and obtain a copy of the PHI including medical records and billing records. A written request must be submitted and a small cost may be involved.

- You may ask us to amend the PHI if you believe they are incorrect. This request must be done in writing. If we deny the request, you may appeal and another health care professional will conduct the review. This applies only to records we have created and not records of other physicians.

- You have the right to have a printed copy of out Patient Confidentiality Notice. This can be obtained at any time from the front desk.

- If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer, Charles Metzger MD, or with Department of Health and Human Services.

This is your copy to keep.