Haywood Pediatric & Adolescent Associates, P.A.

DATE: ____________ **ACCOUNT # _______________**

Please Fill Out Completely!

Child's Name*:* ____
(Last Name*)* (First Name*)* (Middle Name*)*

Date of Birth*:* ______________________________ **SS#:** ___________________________________ **Sex:** Male Female

Race : ☐American Indian ☐Asian ☐Black or African American ☐More than one race ☐White ☐ Hispanic or Latino ☐Prefer not to answer
☐Other: ______________

Ethnicity/Etnicidad: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer **Language Preference** (circle one): English Spanish

Mother's or Guardian's Full Name: ____

Maiden Name ____ SS# __________________________________ Date of Birth ____________________________

Address ____ Home Phone ______________________________
(Mailing Address) (City) (State, ZIP)

Cell Phone _____________________________ Employer ____ Work Phone: _____________________________

Relationship to patient: ☐ Mother ☐ Other: ____

Email ____

Father's or Guardian's Full Name: ____

SS# ____ Date of Birth ____

Address ____ Home Phone ______________________________
(Mailing Address) (City) (State, ZIP)

Cell Phone _____________________________ Employer ____ Work Phone: _____________________________

Relationship to patient: ☐ Father ☐ Other:____

Email ____

Emergency Contact: (Check One) ☐ Mother ☐ Father ☐ Other: ______________________________________ Phone: _____________________________

Name of Insurance: ____

Preferred method of communication: appointment reminders, immunization reminders, etc…

__________ Postal Mail

__________ Phone

__________ Web Message through our Patient Portal

MORE ON THE NEXT PAGE →

Please fill out completely!

Preferred Provider: (please check <u>ONLY</u> one) ☐ Dr. Stephen Wall ☐ Dr. Steven Hammel ☐ Dr. Karin McLelland

☐ Dr. Trew Stransky ☐ Dr. Sara Evers ☐ Anne Sarzynski ☐ Lillian Norris

Authorization for Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Can confidential messages, including reminders, lab and x-ray results or other healthcare information be left on answering machines, cell phone, or work voice mail?

(Circle One) YES NO

Please, list family members that may bring your child to the doctor for diagnosis and treatment. I understand that every effort will be made to contact me in case of accident, serious illness, or hospital admission.

Name: ____ Relationship: ________________________________ Phone: ____________________________

Name: ____ Relationship: ________________________________ Phone: ____________________________

Name: ____ Relationship: ________________________________ Phone: ____________________________

I hereby authorize Haywood Pediatrics to furnish information concerning my child to my insurance carriers, to other medical persons to whom physicians of Haywood Pediatrics have referred my child for treatment, and to the admitting hospital should my child be admitted.

All professional services are charged to the patient. Payment for office charges is due at the time of service. Patients covered under a contracted insurance plan are responsible for any co-payment, deductible, or co-insurance at the time of service. The patient is responsible for all fees regardless of insurance coverage. Updated insurance information must be given at time of services. Failure to do so may obligate you for payment for services rendered. Divorce has no bearing on the responsibility for medical care as it affects third parties. Haywood Pediatrics does not get involved in payment disputes between payments.

I have received a copy of the Notice of Privacy Practices. I consent to medical treatment and diagnostic procedures by Haywood Pediatrics healthcare providers. I have read the above Consent to Use or Disclose Information for Treatment, Payment, or Healthcare Operations and do hereby authorize the release/transmission of pertinent medical information necessary for treatment, payment, or healthcare operations. I have also read and completed the above Authorization for Use and Disclosure of Individually Identifiable Health Information and understand that if I refuse to sign this authorization, the law may allow Haywood Pediatrics to refuse treatment. I am responsible for all charges incurred at Haywood Pediatrics and authorize payment of insurance benefits directly to Haywood Pediatrics. I am responsible for payment of all charges not covered by insurance contracts – including co-payments, deductible, non-covered services, and those determined by the insurance company, where there is no contract with Haywood Pediatrics, to be above the insurance company's usual and customary fee.

I, being the parent or guardian of the above named child/children, do hereby request and authorize Haywood Pediatric and Adolescent Medicine Group to perform necessary services for my child which are deemed advisable by the physician/provider, whether or not I am present at the actual appointment.

Signature of Patient or Responsible Party: ____(SEAL) Date: _________________________

MORE ON THE NEXT PAGE →

MEDICAL HISTORY

BIRTH
Length of pregnancy: ________________________________

Illnesses mother had during pregnancy:

a. Severe vomiting ________________________________
b. Increased blood pressure ________________________________
c. Viruses(flu, colds, etc.) ________________________________
d. Kidney infections ________________________________
e. Depression ________________________________
f. Swelling ________________________________
g. Vaginal bleeding ________________________________
h. Rashes________________________________
i. Hospitalizations ________________________________
j. Other ________________________________

Labor:
Spontaneous________________________________ Induced________________________________
Length of labor (in hours) ____________________

Delivery:
Type: Vaginal ________________ C-Section __________________
Presentation: Vertex (head first) _________________ Breech (buttocks first) __________________

Newborn:
Birth weight: __________________
Problems in hospital nursery (respiratory difficulties, jaundice, blueness, convulsions, bleeding, feeding difficulties, deformities, others): If yes, please explain: ________________________________
____
____

FEEDING
Breast ________________________________ Formula (what kind) ________________________________
Any feeding problems? ________________________________

DEVELOPMENT (age child first performed the following):

a. Rolled over: ________________________________
b. Sat without support: ____________________________
c. Stood unassisted: ______________________________
d. Acquired first tooth: ____________________________
e. Walked alone (more than 4 steps): ________________________________
f. Said first word (other than mama, dada): ________________________________
g. Put two words together (other than bye-bye):________________________________
h. Bladder control most of the time: ________________________________
i. Bowel control most of the time: ________________________________

ALLERGIES
Allergic to:
____
____
____

Type of Reaction (ex. rash, difficulty breathing, etc):
____
____
____

MEDICATIONS CURRENTLY TAKING:
____
____
____

ILLNESSES
List any illnesses or conditions persisting for months or years (ex. Ear infections, allergies, asthma, ADD, seizures, sleep problems, etc.):
____
____
____

MORE ON THE NEXT PAGE →

INJURIES:

Type	Age	Long-Term Effects

SURGERY:

Type	Age	Complications

HOSPITALIZATIONS (other than birth, injuries, surgery):

Diagnosis	Age	Treatment & Outcome

FAMILY HISTORY

Is there any family history of the following (include parents, grandparents, siblings, aunts, & uncles)

1. Asthma
2. Serious allergies
3. Diabetes
4. Seizures
5. Mental retardation
6. Blood disorders
7. Bleeding tendencies
8. Thyroid diseases
9. Liver diseases
10. Kidney disease
11. Rheumatic fever
12. Childhood heart disease
13. Birth defects
14. Death in first year of life
15. Tuberculosis
16. Cancer
17. Obesity
18. High blood pressure
19. Heart attacks before age 50
20. Strokes before age 60
21. Any other condition occurring in 2 or more family members

If yes, list disease or condition below; give relationship of family member to child and give specific diagnoses and circumstances (if known).

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____

____

IMMUNIZATIONS

Please, provide us with a copy of past immunizations from health clinics, schools, or other physicians.

MEDICAL RECORDS

Please, ask for & sign release of records; so we may obtain records from other health clinics, hospitals, or other physicians.

THANK YOU !