Patient's Last Name:______________________First Name:__________________MI____

Address:____

City:_________________________State:_______________Zipcode:_______________

Sex________Birth date_______________Social Security #:___________________________

Home phone:_________________________Cell phone:_____________________________

Language:_________________ **Ethnicity** (check one): _____**Spanish/ Hispanic origin**
_______**Not Spanish/ Hispanic origin** ______**Decline/ Unknown**

Race (circle all that apply): **White; Black/ African American; American Indian/Alaska Native; Asian; Native Hawaiian/ other Pacific Islander; Other; Decline/ Unknown**

Parent's Names:____

Address (if different than above)____

City:_________________________State:_______________Zipcode:_______________

Work phone:________________________ Work phone:__________________________

Emergency contact (**other than parent**)__________________phone:__________________

Primary Ins Co:____

Insured Name:__________________________**DOB:**____________Relationship______

Employer:__________________________________Copay__________________________

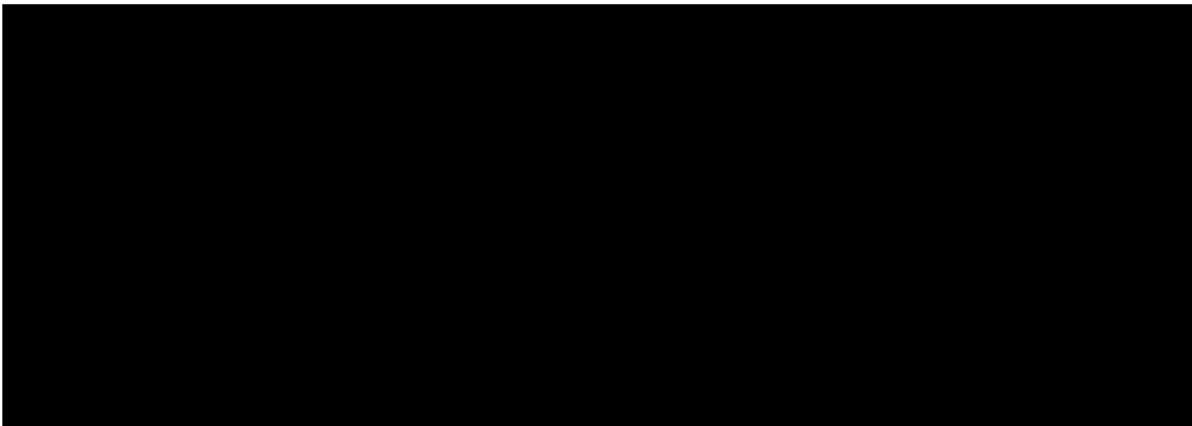
Policy #:_____________________________ Group#:_____________________________

Secondary Ins Co:____

Insured Name:__________________________**DOB:**____________Relationship______

Policy #:_______________________________Group#:____________________________

Employer:__________________________________Copay__________________________



INSURANCE INFORMATION 2014

I hereby certify that the insurance information provided is correct. I know that any incorrect information provided may result in my services not being paid and the responsibility for payment will be mine. Should any of the information change I will notify the office. I will provide my insurance card and date it became effective.

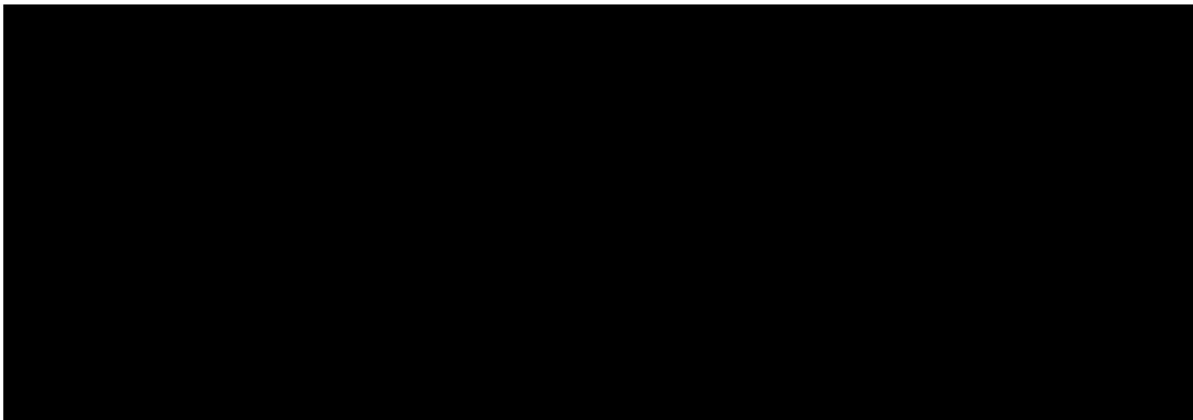
Patient's name________________________________

Parent's name________________________________

Parent's signature____________________________

Date ____

Insurance ____________________________________



Healthcare Authorization

My child, ______________________________, may be brought to doctor

appointments by: _____________________relationship__________________

_____________________relationship__________________

_____________________relationship__________________

This person may:

_____ authorize care

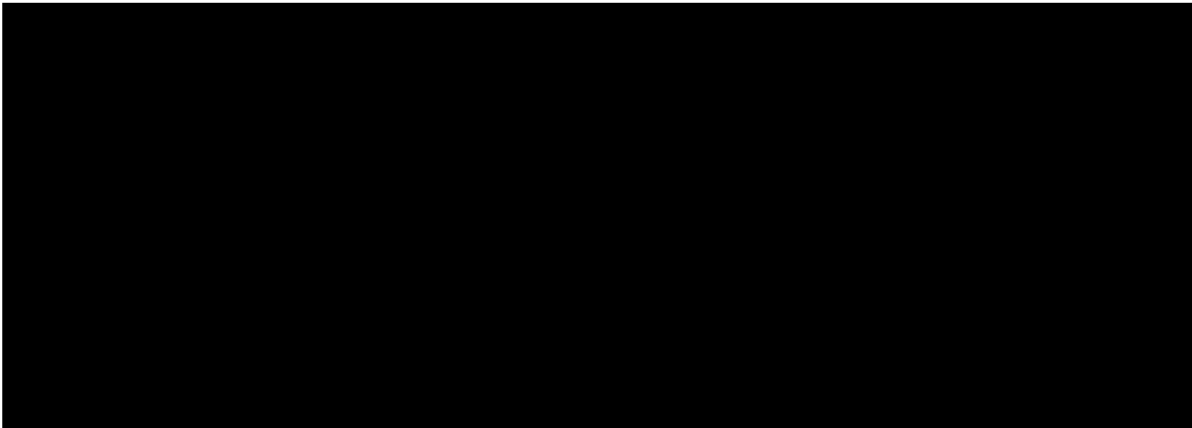
_____ authorize vaccines

_____ be provided with information regarding the appointment

Parent signature: _________________________________

Date: ____

Expiration: ___________________________________



Pediatric Specialists of Franklin County

New Patient History

Name: ______________________ Date of Birth: ______________ M F

Birth History:

Was the patient born at term? Yes No If not, how many weeks gestation? _______

Type of delivery: ___Vaginal ___Cesarean (C-section) why? ______________________

Were there problems at birth or during pregnancy? Yes No. If Yes, please explain: ______________

Did the baby go home from the hospital with you? Yes No

During pregnancy did mother use any of the following: __ Drugs __Alcohol __ tobacco/cigarettes

__ prenatal vitamins __ medications, please list: ______________________

How was your baby fed: __ Breast __Bottle Birth weight: ________ Pass hearing screen? Yes No

Past Medical History:

Does your child have, or has your child ever had:

Illness	Yes	No	Explain
Chickenpox			
Frequent ear infections			
Hearing problems			
Vision problems			
Allergies			
Lung disease (asthma, CF, pneumonia, etc.)			
Heart problems			
Cancer			
Stomach problems			
Urinary Tract Infection			
Kidney disease			
Sleep problems			
Headaches			
Seizures			
Obesity			
Diabetes			
Thyroid disease			
ADHD			
Mood Disorders			
Developmental Delay			
Dental Decay			
Alcohol/drug use			
Tobacco use			

Has your child had any hospitalizations? Yes No If yes, please explain: ______________________

Continued on other side

Pediatric Specialists of Franklin County

New Patient History

Has your child had any significant injuries (broken bones, concussion, etc.)? Yes No If yes, please list:

___

Please list current medications: ___ ___

___ ___ ___

Social History:

Who lives at home with the child?

Name	Relationship to child	Age	List other siblings not living with the patient:

Please list pets that are in the house ___

What are parent's jobs/occupations? ___

Is there exposure to cigarette smoke? Yes No If yes, where: ___ Inside ___Outside __Car

What is the water source? __ town with fluoride __ town without fluoride __well __ other __unsure

Was your home built before 1977? Yes No

Family History:

Have any close family members had the following? (parents, siblings, grandparents)

Illness	Yes	No	Unsure	Who?
Childhood hearing loss				
Allergies				
Asthma				
Tuberculosis				
Heart disease				
High cholesterol				
High blood pressure				
Anemia/Bleeding disorder				
Dental Decay				
Cancer				
Liver disease				
Kidney disease				
Diabetes				
Obesity				
Epilepsy/seizures				
Alcohol/drug abuse				
Mental illness/depression				
Developmental delays				
Immune problems				

Comments ___

Continued on other side