Pediatric Specialists of Franklin County

Patient's Last Name _____ **First Name** _____ **MI** ____
Address_____
City _____State_____Zipcode_____
Sex _____Birth date_____ Social Security #_____
Home phone_____Cell phone_____
Pharmacy Name_____ Location_____
Mother's DOB
Father's DOB

Language_____

Ethnicity (please check one)
_____Not Hispanic or Latino
_____Hispanic or Latino
_____Decline to answer

Race (check all that apply)
_____American Indian or Alaskan Native
_____Asian
_____Black or African American
_____White
_____Native Hawaiian or Other Pacific Islander
_____Decline to answer

Parent's Names_____
Address (if different from above)_____
City_____State_____Zipcode_____
Work phone_____Work phone_____
Emergeny contact (other than parent)_____phone_____

Your privacy is as important to us as it is to you. Rest assured Pediatric Specialists is committed to treating and using your personal health information responsibly. This notice describes the information we will collect, how and when we use or disclose that information, and your rights as they relate to your protected health information.

Signature Parent/ Legal Guardian_____Date_____

Office

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 mother? 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? 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			
HOSPITALIZATIONS?			

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 patient:

Please list pets that are in the house:_____
What are parent's jobs/ occupation: Mother_____ Father _____
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 you home/ residence 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:_____

Pediatric Specialists of Franklin County
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Waynesboro, PA 17268
717-765-6621

PARENTAL AUTHORIZATION TO TREAT MINOR CHILD WHEN NOT ACCOMPANIED BY PARENT OR GUARDIAN

This authorization is for patients under 18 years of age.

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child's records.

Patient's Names _____ **DOB**_____
_____ **DOB**_____
_____ **DOB**_____
_____ **DOB**_____

Yes____ No_____ Patients listed above my present and be treated unaccompanied by an adult.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

Signature: Parent/ Legal Guardian _____Date_____

This authorization will be in effect until changed in writing by the Parent or Legal Guardian above.