

Pediatric Specialists of Franklin County

Patient's Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Sex _____ Birth Date _____ Home Phone _____

Cell Phone _____ Cell Phone _____

Pharmacy Name _____ Location _____

Mother's Name _____ DOB _____

Father's Name _____ DOB _____

Email Address _____

Primary 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

Emergency 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 _____

PEDIATRIC SPECIALIST OF FRANKLIN COUNTY

New Patient History

Name: _____ Date of Birth: _____ M F

Birth History:

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

Type of delivery: ___ Vaginal ___ Cesarean (C-section) Why? _____

Were there problems at birth or during pregnancy? Yes or No if yes, please explain _____

Did the baby go home from the hospital with mother? Yes or 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 or 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			
Cancer			
Urinary Tract Infection			
Kidney disease			
Sleep problems			
Headaches			
Seizures			
Obesity			
Diabetes			
Thyroid disease			
ADHD			
Mood disorders			
Developmental Delay			
Dental decay			
Alcohol use			
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 your 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 Abuse				
Drug Abuse				
Mental Illness				
Depression				
Developmental Delay				
Immune Problems				

Comments: _____

PEDIATRIC SPECIALISTS OF FRANKLIN COUNTY
27 VISTA DR, UNIT 3
WAYNESBORO, PA 17268
717-765-6621

Name: _____ DOB: _____

Insurance (Primary): _____

ID#: _____ Group#: _____

Insured name _____ DOB: _____

Insurance (Secondary): _____

ID#: _____ Group#: _____

Insured name _____ DOB: _____

I hereby authorize ***Pediatric Specialists of Franklin County*** to apply for benefits on my behalf for the covered services rendered by the physician. I request that my insurance company make payment directly to ***Pediatric Specialists of Franklin County***. **I understand that I am responsible for all deductible and co-pay amounts and any/all services not covered by my insurance.** I certify that the insurance coverage information I have provided is correct.

Signature of parent: _____

Relationship: _____

Date: _____