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:_____

Pediatric Specialists of Franklin County

27 Vista Drive, Suite 3

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. Anyone under the age of 18 must be accompanied to the appointment by an adult.

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. If you feel there may be an occasion where your child will be brought by a relative, babysitter, etc., please fill out the following information for us to include with your child's records.

Child's Name_____ **DOB**_____

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.