Pediatric Patient Registration Information

HOW DID YOU HEAR ABOUT US? ☐ NEWSPAPER ☐ SOCIAL MEDIA/WEB SEARCH ☐ INSURANCE REFERRAL ☐ FAMILY/FRIEND

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	REFERRING DOCTOR	SEX: ☐M ☐F

PHYSICAL ADDRESS	CITY	STATE	ZIP

MOTHER'S MAIDEN NAME	RACE	ETHNICITY

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	EMERGENCY PHONE

PATIENT'S INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF POLICY HOLDER	GROUP #

RELATIONSHIP TO PATIENT	PRIMARY COPAY $	COPAY AMT. SPECIALIST $

ADDRESS OF INSURANCE COMPANY	DEDUCTIBLE AMT. SELF	DEDUCTIBLE AMT. FAMILY

EFFECTIVE DATE	EXPIRATION DATE

PARENTS' INFORMATION

MOTHER'S NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE		: ☐ ☐

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email	MARITAL STATUS	MAIDEN NAME	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

FATHER'S NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE		: ☐ ☐

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email	MARITAL STATUS	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

CUSTODIAL INFORMATION

CUSTODIAL PARENT IS
☐Mother ☐Father ☐Other_____

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Brightstarts Pediatrics PC, to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Brightstarts Pediatrics PC,

TREATMENT IF PARENT OR GUARDIAN IS NOT PRESENT: CHILD MUST must have a note from a parent or guardian giving permission for Brightstarts Pediatrics PC, to examine child. Please Include in this note the date of visit, any known allergies, the name of the person bringing in the child and his or her relationship to the child, and reason for visit. Forms are available if you'd like to have one for reference. Please ask the Receptionist for details.

Patient / Guardian Signature _____ Date _____ Relationship to Patient _____

Patient Financial Agreement

PATIENT INFORMATION

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. **Initials** _____

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived. **Initials** ____

Checks: Returned checks may be subject to a $30.00 fee. **Initials** ____

Cash Pay Patients: The amounts you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, X-ray tests, any injections, special procedures or additional office visit charges. **Initials** ____

Claims Submission: As a courtesy, Brightstarts Pediatrics PC, will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency. **Initials** ____

Preventative Care Services: Routine exams may be covered by your insurance. When a medical concern is addressed at the time of your visit, preventative benefits will no longer apply. Additional fees may incur including but not limited to co-pays, deductibles and co-insurance. **Initials** ____

Ancillary Services: Laboratory and outpatient radiology procedures will be billed separately by an outside provider. Please contact them directly with any questions regarding your bill. **Initials** ____

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Palomar Health Medical Group for all services rendered. **Initials** ____

Missed Appointments: Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

I have read and understand the above statements. I**nitials** ____

I agree to comply with the financial policies of Brightstarts Pediatrics PC, and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____

Patient / Guardian Signature Date

_____ _____

Patient Name (Please print) Date of Birth

Authorization For Third Party To Consent To Treatment of Minor Lacking Capacity To Consent

I am the ☐ Parent
☐ Guardian
☐ Other person having legal custody _____
(describe legal relationship)

of (name of minor)_____, a minor.

I hereby authorize (name of agent) _____, to act as my agent to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor or dentist, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-name agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or dentist recommends.

This authorization is given pursuant to the provisions of Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above-name minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of the minor to the above- named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

This authorization shall remain effective until (month and day) _____, 20 _____, unless sooner revoked in writing delivered to the agent named above.

_____ _____ AM/PM
Date Time

_____
Signature (circle relationship: parent/legal representative/person having legal custody)

_____
Print Name (circle relationship: parent/legal representative/person having legal custody)

_____
Signature (parent)

Medically Relevant Information

Minor's Name: _____

Minor's date of birth: _____

Allergies to drugs or food: _____

Conditions for which is currently being treated: _____

_____

Current medications: _____

_____

Authorization For Third Party To Consent To Treatment of Minor Lacking Capacity To Consent

Restrictions on activity: _____

Primary care physician (name and telephone number): _____

_____

Insurance Company: _____

Mother's name: _____

Mother's address: _____

Mother's telephone numbers: _____ (WORK) _____ (HOME) _____ (OTHER)

Father's name: _____

Father's address: _____

Father's telephone numbers: _____ (WORK) _____ (HOME) _____ (OTHER)

BRIGHTSTARTS PEDIATRICS, P.C.

HIPAA Privacy Standards

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations. Your health information may be used as necessary to support the day-to-day activities and management of Brightstarts Pediatrics, P.C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audit and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Information about treatments. Your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the (federal privacy standards. These include:

** the right to request restrictions on the use and disclosure of your protected health information
** the right to receive confidential communications concerning your medical condition and treatment
** the right to inspect and copy your protected health information
** the right to amend or submit corrections to your protected health information
** the right to receive an accounting of how and to whom your protected health information has been disclosed
** the right to receive a printed copy of this notice

NOTE: There is a charge for copying a medical record or any part of a medical record. All fees will be paid in advance. This fee is set by the State of Alabama.

BRIGHTSTARTS PEDIATRICS, P.C. DUTIES

We are requires-by law to maintain the privacy of your protected health information and- to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the privacy officer.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Privacy Officer, Brightstarts Pediatrics, PC, 102 Essex Ct, Suite A, Madison, AL - 35758. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practice is:
Privacy Officer, Brightstarts Pediatrics, PC, 102 Essex Ct, Suite A, Madison, AL - 35758, (256) 461-8442

EFFECTIVE DATE

This Notice is effective on or after August 1, 2004
Revised Date: July, 31st, 2024

Notice Of Privacy Practices

Patient Label Here

Patient Name: _____

DOB: _____ MRN: _____

Acknowledgement of Receipt

PATIENT INFORMATION

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Patient / Guardian Signature Date

_____ _____
Patient Phone XXX-XXX-XXXX Name of Physician

By signing this form, the patient acknowledges receipt of the "Notice of Privacy Practices" of Brightstarts Pediatrics PC. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information. We encourage you to read it in full.

I acknowledge receipt of the "Notice of Privacy Practices" of Brightstarts Pediatrics PC.

_____ _____
Patient / Guardian Signature Date

_____
If legal representative, state relationship to patient

☐ I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is: _____

Pediatric Health History

NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	SEX: ☐M ☐F	TODAY'S DATE
ADDRESS	PHONE		EMAIL

PHARMACY

PHARMACY	ADDRESS	PHONE #
PHARMACY	ADDRESS	PHONE #

MEDICATIONS, OVER THE COUNTER MEDICATIONS & VITAMINS

DRUG NAME, STRENGTH, FREQUENCY	DRUG NAME, STRENGTH, FREQUENCY

PEDS ALLERGIES

NOTE: ALLERGIES ENTERED HERE WILL NOT BE CHECKED AGAINST THE CURRENT MEDICATION LIST. INCLUDES FOOD AND DRUG ALLERGIES AND ADVERSE DRUG REACTIONS.

☐ ACETAMINOPHEN (TYLENOL)	☐ CIPROFLOXACIN (CIPRO)	☐ IMIPRAMINE (TOFRANIL)	☐ PROPRANOLOL (INDERAL)
☐ ALBUTEROL	☐ CLARITHROMYCIN (BIAXIN)	☐ INSULIN	☐ PROPOXYPHENE (DAVON)
☐ AMOXICILLAN	☐ CLONAZEPAM (KLONOPIN)	☐ IODINE OR SHELLFISH	☐ QUINOLONES
☐ AUGMENTIN	☐ CLONIDINE (CATAPRESS)	☐ ISOTRETINOIN (ACCUTANE™)	☐ RISPERIDONE (RISPERIDAL)
☐ AMPHETAMINE SALTS (ADDERALL)	☐ CLOZAPINE (CLOZARIL)	☐ LANSOPRAZOLE (PREVACID)	☐ SULFA
☐ AMPICILLIN	☐ CODEINE	☐ LATEX	☐ TETANUS TOXOID
☐ ASPIRIN	☐ CONTRAST MEDIA (CONRAY)	☐ LEVALBUTEROL HCL (XOPENEX)	☐ TETRACYCLINE
☐ ATOMEXTINE (STRATTERA)	☐ CORTISPORIN (OTIC)	☐ LEVOFLOXACIN (LEVAQUIN)	☐ TMP/SMX (BACTRIM)
☐ AZITHROMYCIN (ZITHROMAX)	☐ DESMOPRESSIN (DDAVP)	☐ LIDOCAINE (XYLOCAINE)	☐ VALPROIC ACID (DEPAKOTE)
☐ BUPROPION HCL (WELLBUTRIN)	☐ DEXTROAMPHETAMINE	☐ MEPERIDINE (DEMEROL)	☐ VANCOMYCIN
☐ BUSPIRONE (BUSPAR)	☐ DIAZEPAM (VALIUM)	☐ METHYLPHENIDATE (RITALIN)	**FOOD / OTHER ALLERGIES**
☐ CARBAMAZEPINE (TEGRETOL)	☐ DICLOXACILLIN (DYNAPEN)	☐ METRONIDAZOLE (FLAGYL)	
☐ CARBAMIDE PEROXIDE (DEBROX)	☐ DIPHENHYDRAMINE (BENADRYL)	☐ MINOCYLCLINE (MINOCIN)	
☐ CEFACLOR (CECLOR)	☐ DOXYCYCLINE (VIBRAMYCIN)	☐ MONTELUKAST (SINGULAIR)	
☐ CEFADROXIL (DURICEF)	☐ ENALAPRIL MALETE (VASOTEC)	☐ MORPHINE	
☐ CEFAZOLIN (ANCEF)	☐ ERYTHRYOMYCIN	☐ NAPROXEN (NAPROSYN)	
☐ CEFDINIR (OMNICEF)	☐ ETODOLAC (LODINE)	☐ NEOMYCIN	
☐ CEFDITOREN (SPECTRACEF)	☐ FAMOTIDINE (PEPCID)	☐ NIACIN (NICOBID)	
☐ CEFEPIME (MAXIPIME)	☐ FLUCONAZOLE (DIFLUCAN)	☐ OFLOXACIN (FLOXIN)	
☐ CEFPROZIL (CEFZIL)	☐ FLUXETINE (PROZAC)	☐ OMEPRAZOLE (PRILOSEC)	
☐ CEFTIZOXIME (CEFIZOX)	☐ FUROSEMIDE (LASIX)	☐ OXYCODONE	
☐ CELECOXIB (CELEBREX)	☐ HALOPERIDOL (HALDOL)	☐ PENICILLIN (PEN-VEE K)	
☐ CEPHALEXIN (KEFLEX)	☐ HEPARIN	☐ PHENYTOIN NA (DILANTIN)	
☐ CIMETIDINE (TAGAMET)	☐ IBUPROFEN (ADVIL, MOTRIN)	☐ POLYMYXIN B	

Pediatric Health History

MEDICAL HISTORY

☐ ABDOMINAL PAIN	ONSET DATE	☐ FRACTURE	ONSET DATE
☐ ACNE	ONSET DATE	☐ GERD	ONSET DATE
☐ ADD	ONSET DATE	☐ HEAD INJURY	ONSET DATE
☐ ADHD	ONSET DATE	☐ HEADACHE, MIGRAINE	ONSET DATE
☐ ALLERGIC RHINITIS	ONSET DATE	☐ HEADACHES	ONSET DATE
☐ ALLERGIES	ONSET DATE	☐ HEARING PROBLEMS	ONSET DATE
☐ ANEMIA	ONSET DATE	☐ HEART MURMUR	ONSET DATE
☐ ASTHMA	ONSET DATE	☐ MICROGNATHIA	ONSET DATE
☐ BIRTH TRAUMA	ONSET DATE	☐ MICROTIA	ONSET DATE
☐ BLEEDING DISORDER	ONSET DATE	☐ QTITIS MEDIA, RECURRENT	ONSET DATE
☐ BRONCHIOLITIS	ONSET DATE	☐ PNEUMONIA	ONSET DATE
☐ BRONCHITIS	ONSET DATE	☐ PREMATURITY	ONSET DATE
☐ CHICKENPOX	ONSET DATE	☐ PYELONEPHRITIS	ONSET DATE
☐ CONCUSSION	ONSET DATE	☐ SEIZURE DISORDER	ONSET DATE
☐ CONGENITAL HEART DISEASE	ONSET DATE	☐ SEIZURES, FEBRILE	ONSET DATE
☐ CONSTIPATION	ONSET DATE	☐ URINARY TRACT INFECTION	ONSET DATE
☐ DIABETES	ONSET DATE	☐ VESICOURETERAL REFLUX	ONSET DATE
☐ ECZEMA	ONSET DATE		

☐ OTHER	ONSET DATE	☐ OTHER	ONSET DATE
☐ OTHER	ONSET DATE	☐ OTHER	ONSET DATE
☐ OTHER	ONSET DATE	☐ OTHER	ONSET DATE

SURGICAL HISTORY

☐ ADENOIDECTOMY	DATE	☐ HERNIA REPAIR, UMBILICAL	DATE
☐ APPENDECTOMY	DATE	☐ LYMPH NODE BIOPSY/EXCISION	DATE
☐ BLOOD TRANSFUSION	DATE	☐ TONSILLECTOMY	DATE
☐ DENTAL SURGERY	DATE	☐ UMBILICAL HERNIA REPAIR	DATE
☐ HERNIA REPAIR, INGUINAL	DATE		

☐ OTHER	DATE	☐ OTHER	DATE
☐ OTHER	DATE	☐ OTHER	DATE
☐ OTHER	DATE	☐ OTHER	DATE

Pediatric Health History

FAMILY HISTORY ☐ None

RELATIONSHIP	☐ ALIVE AND WELL
FAMILY MEMBER NAME	☐ DECEASED
☐ ADD / ADHD ONSET AGE	☐ CAUSE OF DEATH
☐ ALLERGIES ONSET AGE	☐ CAUSE OF DEATH
☐ ASTHMA ONSET AGE	☐ CAUSE OF DEATH
☐ BIRTH DEFECTS ONSET AGE	☐ CAUSE OF DEATH
☐ CANCER ONSET AGE	☐ CAUSE OF DEATH
☐ CARDIOVASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ DEAFNESS ONSET AGE	☐ CAUSE OF DEATH
☐ DEPRESSION ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DELAY ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DISLOCATION OF HIP ONSET AGE	☐ CAUSE OF DEATH
☐ DIABETES ONSET AGE	☐ CAUSE OF DEATH
☐ ECZEMA ONSET AGE	☐ CAUSE OF DEATH
☐ ELEVATED LIPIDS ONSET AGE	☐ CAUSE OF DEATH
☐ GENETIC DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ HEMOGLOBINOPATHY ONSET AGE	☐ CAUSE OF DEATH
☐ HYPERTENSION ONSET AGE	☐ CAUSE OF DEATH
☐ LEARNING DISABILITY ONSET AGE	☐ CAUSE OF DEATH
☐ MENTAL RETARDNESS ONSET AGE	☐ CAUSE OF DEATH
☐ MIGRANES ONSET AGE	☐ CAUSE OF DEATH
☐ OBESITY ONSET AGE	☐ CAUSE OF DEATH
☐ RENAL DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ SEIZURE DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ STRABISMUS ONSET AGE	☐ CAUSE OF DEATH
☐ SUDDEN INFANT DEATH SYNDROME ONSET AGE	☐ CAUSE OF DEATH
☐ THYROID DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ OTHER ONSET AGE	☐ CAUSE OF DEATH

FAMILY HISTORY – Continued

RELATIONSHIP	☐ ALIVE AND WELL
FAMILY MEMBER NAME	☐ DECEASED
☐ ADD / ADHD ONSET AGE	☐ CAUSE OF DEATH
☐ ALLERGIES ONSET AGE	☐ CAUSE OF DEATH
☐ ASTHMA ONSET AGE	☐ CAUSE OF DEATH
☐ BIRTH DEFECTS ONSET AGE	☐ CAUSE OF DEATH
☐ CANCER ONSET AGE	☐ CAUSE OF DEATH
☐ CARDIOVASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ DEAFNESS ONSET AGE	☐ CAUSE OF DEATH
☐ DEPRESSION ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DELAY ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DISLOCATION OF HIP ONSET AGE	☐ CAUSE OF DEATH
☐ DIABETES ONSET AGE	☐ CAUSE OF DEATH
☐ ECZEMA ONSET AGE	☐ CAUSE OF DEATH
☐ ELEVATED LIPIDS ONSET AGE	☐ CAUSE OF DEATH
☐ GENETIC DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ HEMOGLOBINOPATHY ONSET AGE	☐ CAUSE OF DEATH
☐ HYPERTENSION ONSET AGE	☐ CAUSE OF DEATH
☐ LEARNING DISABILITY ONSET AGE	☐ CAUSE OF DEATH
☐ MENTAL RETARDNESS ONSET AGE	☐ CAUSE OF DEATH
☐ MIGRANES ONSET AGE	☐ CAUSE OF DEATH
☐ OBESITY ONSET AGE	☐ CAUSE OF DEATH
☐ RENAL DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ SEIZURE DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ STRABISMUS ONSET AGE	☐ CAUSE OF DEATH
☐ SUDDEN INFANT DEATH SYNDROME ONSET AGE	☐ CAUSE OF DEATH
☐ THYROID DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ OTHER ONSET AGE	☐ CAUSE OF DEATH

OB GYN HISTORY

LAST PERIOD:	☐ LIGHT BLEEDING	FLOW DURATION:	☐ REGULAR CYCLES	LAST PAP SMEAR:
PADS USED IN 24HR:	☐ HEAVY BLEEDING	AGE OF FIRST PERIOD:	☐ IRREGULAR CYCLES	☐ PAST ABNORMAL PAP
☐ TAMPON USE	PREGNANCIES (GRAVID)	DELIVERIES (PARA):		☐ MENOPAUSE

Pediatric Health History

PREGNANCY / BIRTH HISTORY – For Children Under 1 Year Of Age

☐ DETAILED DOCUMENT	LAST DETAILED DOC DATE
☐ REVIEWED	COMMENTS
☐ HISTORY UNOBTAINABLE	

PREGNANCY / BIRTH HISTORY – Antenatal

MATERIAL AGE	EDC	MARITAL STATUS	LIVES WITH FOB ☐ NO ☐ YES
GRAVIDA	PARA	AB	LIVING

PRENATAL CARE GIVEN ☐ NO ☐ YES

MATERNAL BLOOD TYPE ☐ RH POSITIVE ☐ RH NEGATIVE

ULTRASOUND RESULTS ☐ NORMAL ☐ ABNORMAL

GROUP B STREP SCREEN ☐ NEGATIVE ☐ POSITIVE

ANTENATAL LABS ☐ NO ☐ YES

MATERNAL ILLNESS / COMPLICATIONS ☐ NO ☐ YES

MATERNAL INFECTIONS ☐ NO ☐ YES

LIVES WITH FOB ☐ NO ☐ YES

MEDICATIONS DURING PREGNANCY

CONFIDENTIAL INFORMATION

PREGNANCY / BIRTH HISTORY – Hospital Course

VITAMIN K INJECTION ☐ NO ☐ YES

HEP B VACCINE ☐ NO ☐ YES

HEARING TEST ☐ PASS ☐ FAIL

INFANT BLOOD TYPE ☐ RH POSITIVE ☐ RH NEGATIVE COOMBS _____

JAUNDICE ☐ NO ☐ YES

PHOTOTHERAPY ☐ NO ☐ YES

SEPSIS EVALUATION ☐ NO ☐ YES

FETAL DISTRESS ☐ NO ☐ YES

OXYGEN REQUIRED ☐ NO ☐ YES

STAYED IN NICU ☐ NO ☐ YES

STAYED IN NURSERY
DAYS REASON

BIRTH DEFECTS ☐ NO ☐ YES

STATE SCREENING DONE ☐ NO ☐ YES

MEDICATION GIVEN ☐ NO ☐ YES

CIRCUMCISED ☐ NO ☐ YES

☐ TURNER SYNDROME ☐ DOWN SYNDROME

PREGNANCY / BIRTH HISTORY – Labor & Delivery

TYPE OF DELIVERY	☐ SGA ☐ AGA ☐ LGA ☐ SROM ☐ AROM HOURS
	APGAR SCORE 1 MIN 5 MIN 10 MIN
TIME OF BIRTH _____HOUR _____MIN ☐ AM ☐ PM	MECONIUM ☐ NO ☐ YES
TIME OF BIRTH / HOURS OF LABOR	MATERNAL FEVER ☐ NO ☐ YES
GESTATION AGE AT BIRTH ☐ RH POSITIVE ☐ RH NEGATIVE	RESUSCITATION ☐ NO ☐ YES
BIRTH WEIGHT _____LBS _____OZ / LENGTH _____CM _____IN	HEAD CIRCUM _____CM _____IN

PREGNANCY / BIRTH HISTORY – Discharge

FEEDING HISTORY ☐ BREAST ☐ BOTTLE ☐ BOTH

FORMULA TYPE

DISCHARGE DATE	TIME HOUR _____ MIN _____ ☐ AM ☐ PM
DISCHARGE TIME	DISCHARGE WEIGHT _____LBS _____OZ

SOCIAL SERVICE REFERRAL ☐ NO ☐ YES

ADOPTION ☐ NO ☐ YES