Patient's Name- **Date of Birth-**

Update: Family History

Please check off if anyone in the immediate family (mom, dad or siblings) have any of the following, and provide a brief explanation somewhere on the paper. If no one has anything please check N/A for not applicable.

	MOM	DAD	SIBLINGS	N/A
1.) Alcoholism				
2.) Substance Abuse				
3.) Diabetes-Type 1 or 2				
4.) High Cholesterol / Triglycerides				
5.) High Blood Pressure				
6.) Asthma				
7.) Allergies				
8.) Eczema				
9.) Kidney Disease				
10.) Heart Disease or Stroke before age 60				
11.) Thyroid Disease				
12.) Bleeding/Clotting Problems				
13.) Birth Defects				
14.) Inherited/Genetic Disease				
15.) Psychiatric Disorders				
16.) Seizures				
17.) ADHD				
18.) Other				

If other is indicated…Please use space below to explain.

Community Care Physicians Pediatric Patient Registration Form

Date: _____ **Patient ID#:** _____
(for office use only)

PATIENT INFORMATION

Social Security Number _____/_____/_____ (Providing your SSN is optional. However, for patients with certain insurances this information may help us determine eligibility for certain health benefits).

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

Legal Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: ( ) _____

Cell #: ( ) _____ Preferred daytime phone: □ Home □Work □ Cell

Date of Birth: _____/_____/_____ Gender: □ Male □ Female □ Other _____

E-mail Address: _____ **Would you like to participate in the patient portal?**
□ Yes □ No

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore, we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
□ American Indian/Alaska Native
□ Asian
□ Native Hawaiian or other Pacific Islander
□ Black/African American
□ White
□ Other

Ethnicity: Select One
□ Hispanic/Latino
□ Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ Emergency Contact DOB: _____/_____/_____

Emergency Phone: ( ) _____ Relationship to Patient: _____

Mother's maiden name _____
First Name Maiden Name

Primary Care Physician: _____ Referring Physician: _____

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

□ E-Mail (when available) □ Text □ Office may leave a message at home

Please Complete Page 2

Community Care Physicians Pediatric Patient Registration Form

FINANCIALLY RESPONSIBLE PARTY

In accordance with Community Care Physicians' Financial Policy, this is defined as the adult accompanying a child under the age of 18, and/or the parent or guardian of the child. This is the person who will receive bills and correspondence. ***Co-pays are due and expected at time of service.***

Financially Responsible Parent/Guardian's Last Name _____ First _____

Relationship to Patient □Mother □Father □Other: _____

Address □ Same as Above Street: _____ City/State/Zip _____

Home Phone # ( ) _____ Work Phone # ( ) _____ Cell Phone # ( )_____

Date of Birth ____/_____/_____ Guarantor: □ Yes □ No

Other Parent/Guardian's Last Name_____ First _____

Relationship to Patient: □ Mother □ Father □ Other _____

Address □ Same as Above Street: _____ City/State/Zip _____

Home Phone # ( ) _____ Work Phone # ( ) _____ Cell Phone # ( ) _____

Date of Birth ____/_____/_____ Guarantor: □ Yes □ No

MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $_____ Policy ID # _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $ _____ Policy ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

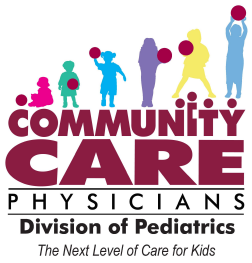
I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when they accept assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my Provider, to release any information necessary for my course of treatment.

_____ _____/_____/_____

Signature of Patient / Guardian Date



AUTHORIZATION FOR TREATMENT

WHO IS AUTHORIZED TO BRING CHILD FOR MEDICAL CARE

I, _____ (name of custodial parent),

give permission for _____ to bring my child/children in for medical care.

WHAT TREATMENT CAN THEY CONSENT TO

_____ vaccine administration

_____ medication to be given to my child in office

TO WHOM CAN WE RELEASE MEDICAL INFORMATION OR HEALTH FORMS

_____ SCHOOL

_____ DAYCARE/BABYSITTER

_____ CAMP/SPORT CLUB

This permission will remain in effect until I withdraw permission in written form.

_____ Childs's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

Parental Signature _____ Date _____

Main Phone #- _____

Community Care Pediatrics { Saratoga & Malta }

COMMUNITY CARE PEDIATRICS-SARATOGA

PEDIATRIC HEALTH HISTORY FORM

Child's Name		Date			
Child's Previous doctor/ Primary Care Provider		DOB		Age	
Allergies/Reactions:					

PRESENT HEALTH CONCERNS	**MEDICATIONS/VITAMINS**	**HERBS/HOME REMEDIES**

PREGNANCY AND BIRTH	
1.	Is this child your by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:
2.	Please indicate any medical problems during pregnancy: ☐ None ☐ Specify:
3.	Delivered by: ☐ Vaginal Birth ☐ Caesarean If caesarean, why:
4.	Birth Weight: Birth Length:
5.	Please indicate any medical problems during the baby's newborn period: ☐ None If premature, how early?
	Other problems:
NUTRITION AND FEEDING	
1.	Was your child breastfed? ☐ No ☐ Yes If so, how long?
2.	Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, specify:
3.	Milk intake now: Type ☐ Cow milk (☐ non-fat ☐ 1% fat ☐ 2% fat ☐ whole milk) ☐ Soy milk ☐ Rice milk
	Average ounces per day (Note: 8 ounces are in 1 cup):
SLEEP	
Hours per night:	Naps (number and length):
Any sleep problems: ☐ No	☐ Yes, explain:
DEVELOPMENT	
At what age did your child: Sit alone:	Walk alone: Say words: Toilet train (daytime):
Girls only: Age at first menstrual period:	
DENTAL HISTORY	
Has child been seen by a dentist? ☐ No ☐ Yes	If so, how often: Date of last visit:
IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.	
Has your child had chickenpox ☐ No ☐ Yes	
EXPOSURES/HABITS:	Any concerns about lead exposure (old home/plumbing/peeling paint)? ☐ No ☐ Yes
Do any household members smoke? ☐ No ☐ Yes	
TV hours per day:	Computer hours per day: Video games hours per day?
PAST MEDICAL HISTORY: Please describe any major medical problems and their dates:	
ADDITIONAL HISTORY DISCUSSED: HOSPITALIZATIONS/OPERATIONS/BROKEN BONES/SEVERE SPRAINS (WITH DATES)	

FAMILY HISTORY Please check off any family history of the following (indicate who has/had the condition)		
☐ Alcoholism/Drug Abuse	☐ Heart Disease or Stroke before age 60	☐ Inherited/Genetic Diseases
☐ High Blood Pressure	☐ Thyroid Disease	☐ Psychiatric Disorders
☐ Asthma/Hayfever/Eczema	☐ Bleeding/Clotting Problems	☐ Seizures
☐ Kidney Disease	☐ Birth Defects	
SOCIAL HISTORY	Birthplace:	Current (or upcoming) grade:

Who lives at home:			
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:

Are the child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced If divorced, when?	
Parent's Occupation: Mother:	Father:
Child care situation ☐ Parents ☐ Other (specify who and hours per day):	
Concerns about your child: ☐ Alcohol use ☐ Tobacco ☐ Sexual activity ☐ Aggressive behavior	
Is violence at home a concern: ☐ No ☐ Yes	Are there guns in the home? ☐ No ☐ Yes
SCHOOL HISTORY	Did/does your child attend preschool? ☐ No ☐ Yes Current Grade:
Name of school**:**	Any concerns about school performance?
Any concerns about relationships with: Teachers ☐ No ☐ Yes, explain: Students ☐ No ☐ Yes, explain:	
If over 4 years old, does your child have a best friend? ☐ No ☐ Yes	
Sports/exercise: Type:	How often? How long (minutes):

REVIEW OF ORGAN SYSTEMS: IF CHILD HAS MORE THAN ONE SYMPTOM IN A LINE, CIRCLE THE RELEVANT ONE(S).

Constitutional/Endocrine ☐ Fevers/chills/excessive sweating ☐ Unexplained weight loss/gain	Gastrointestinal ☐ Nausea/vomiting/diarrhea ☐ Constipation ☐ Blood in bowel movement	Allergy ☐ Hayfever/itchy eyes
Eyes ☐ Squinting/"crossed" eyes/asymmetric gaze	Cardiovascular ☐ Tires easily with exertion ☐ Shortness of breath ☐ Fainting	Skin ☐ Rashes ☐ Unusual moles
Ears/Nose/Throat ☐ Unusually loud voice/hard of hearing ☐ Mouth breathing/snoring ☐ Bad breath ☐ Frequent runny nose ☐ Problems with teeth/gums	Genitourinary ☐ Bedwetting ☐ Pain with urination ☐ Discharge: penis or vagina	Psychiatric ☐ Speech problems ☐ Anxiety/Stress ☐ Problems with sleep/nightmares ☐ Depression ☐ Nail biting/thumbsucking ☐ Bad temper/breath holding/jealousy
Respiratory ☐ Cough/wheeze	Neurological ☐ Headaches ☐ Weakness ☐ Clumsiness	Blood/Lymph ☐ Unexplained lumps ☐ Easy bruising/bleeding
Muscular ☐ Muscle/join pain		