



Patient Demographic and Medical History Form/Update Form

The following questionnaire will provide our staff information to best handle your individual billing, communication and health needs.

PATIENT INFORMATION

Patient: Last First Middle (Nickname)
M () F ()

BIRTH DATE Sex

Child's Social Security # (must be registered for proper filing of insurance(s))

Address

City State Zip Code

Home Phone (including area code) Cell Phone

Race/Ethnicity

- American Indian/Alaskan Asian African American/Black Caucasian/White Hawaiian/Pacific Islander Other Decline

Primary Language _____

Does this child live with: Father? Mother? Other Adult?

GUARDIAN INFORMATION

Mother: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

Father: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

EMERGENCY CONTACT INFORMATION

Nearest Relative: Last First Relationship

Phone Number (1) Phone Number (2)

PARTY RESPONSIBLE FOR BILLING

(Must be present at this appointment, provide picture ID card and sign bottom of this sheet)

Last First Middle Relationship to Patient

Same as information listed under Guardian Info

BIRTH DATE Social Security #

Address

City State Zip Code

Home Phone (including area code) Cell Phone

Email: (optional)

INSURANCE INFORMATION

Subscriber Name L/F/M (Primary Insurance Holder) Relationship to Pt.

Same as information listed under Guardian Info

BIRTH DATE Social Security #

Insurance Company Name Plan Type (PPO,HMO, Options, etc)

Subscriber ID # (Member ID) Group #

Insurance Company Address (Back of Card)

Insurance Company Phone Number (Back of Card)

Employer providing Insurance Phone

FAMILY INFORMATION

Brothers and Sisters DOB Health Issues?

PHARMACY INFORMATION

Pharmacy Name: Location

PRIOR CARE INFORMATION

What Doctor/Clinic has taken care of this child in the past? City Phone

CONTINUED ON BACK >>>

It is the Guarantor's responsibility to know if Alliance Pediatrics participates in your insurance plan or network. Do this prior to seeing the Physician. I hereby give annual authorization for payment of insurance benefits to be made directly to Alliance Pediatrics, PA for services rendered. I am financially responsible for all charges whether or not they are covered by insurance. I agree to pay all costs of collection and reasonable attorney's fees. I authorize the provider to release all information necessary to secure the payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original. I also consent to receive calls, texts and emails from Alliance Pediatrics for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Guarantor's Signature: _____

Date: _____

Medical Information and History Form/Update Form

All responses are kept confidential

Today's Date: _____

Patient Name

Date of Birth

Time of Birth (Newborn)

1. Were there any problems during the pregnancy or birth of this child?
 Yes No

If Yes, please explain

2. Has your child ever had any significant medical problems (including heart, liver, kidney problems, allergies, asthma, frequent infections, behavioral, growth, or mental or developmental problems)?
 Yes No

If Yes, please explain

3. Do any immediate family members have significant medical problems?
 Yes No

If Yes, please explain

4. Is there any family history of the following (please circle):
Heart disease before age 50, Diabetes, Cancer, Tuberculosis, Asthma, Allergies, Inherited Childhood Disease, Sickle Cell Anemia?

5. Does either parent have a total cholesterol over 240?
 Yes No

6. Any hospitalizations, accidents or surgery?
 Yes No

If Yes, please explain

7. Any medication allergies?
 Yes No

If Yes, list and describe

8. Any food or environmental allergies?
 Yes No

If Yes, list and describe

9. Are your child's immunizations up to date? (Please furnish records)
 Yes No

10. Does your child attend daycare? If so, where?
 Yes No

If Yes, please list

11. Does your child have any school or learning problems?
 Yes No

If Yes, please explain

12. Who lives in your home?

13. Are there any serious marital or family problems?
 Yes No

If Yes, please explain

14. Who smokes in the home? _____

Who has Legal Medical Decision Making Rights for this child ?

Name Relation to child

Name Relation to child

15. Do you feel safe at home? Yes No

16. Are there pets at home? Yes No

17. What is the child's primary source of water?
 City Well Bottle

18. Is the water fluorinated? Yes No

19. Does the entire family wear seat belts in the car?
 Yes No

20. Is the patient taking any OTC/Prescription Medications?

21. Are you seeing a specialist that we have not referred you to?

22. Is there anything we can provide you to help us better care for your child, such as hearing, vision, or reading accommodations?

RISK SCREENINGS

Lead Exposure Risk:

Does your child live in or regularly visit a house built before 1960 with peeling/chipping paint or recent renovation?

Yes No

Does your child have a sibling, housemate, or playmate with lead poisoning or a high lead level?

Yes No

Is there an adult at home whose job or hobby involves lead exposure?

Yes No

Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

Yes No

TB(Tuberculosis) Risk Assessment:

Are you or the child foreign born?

Yes No

Do you have a family history of TB? Yes No

Is there an adult with HIV infection in or around the family?

Yes No

Do you have a family member who has been in jail within the past 5 to 10 years?

Yes No

Do you have or care for foster children who may be at risk for TB or whose medical histories are missing?

Yes No

Do you live in a high-risk neighborhood or in one with migrant families or homeless?

Yes No

FOR OFFICE USE ONLY

Initials of Reviewing Provider

Date

