PLEASE PRINT

PATIENT		Today's Date _____		Patient Registration		**Please Complete All Areas**			
		Pharmacy (Please list the pharmacy you use for prescriptions.)		NAME		LOCATION (TOWN)			
	List Each Child in the Family	First Child	FIRST NAME ETHNICITY	MIDDLE	LAST	DOB	SEX (M – F)	RACE	
		Second Child							
		Third Child							
		Fourth Child							
		Fifth Child							
	The parent filling out this sheet	PARENT LAST NAME			PARENT FIRST NAME & INITIAL:				
		ADDRESS LINE 1							
		ADDRESS LINE 2			RACE	ETHNICITY	MARITAL STATUS		
		CITY			STATE	ZIP			
		HOME PHONE		CELL PHONE OR PAGER	SSN	DATE OF BIRTH			
		EMPLOYER		EMPLOYER ADDRESS	EMPLOYER PHONE				
BIOLOGICAL	Enter the other Biological or Adoptive Parent	LAST NAME		FIRST NAME & INITIAL:	RELATIONSHIP:				
		ADDRESS							
		CITY		STATE	ZIP	MARITAL STATUS			
		HOME PHONE		CELL PHONE	RACE	ETHNICITY			
		DATE OF BIRTH		SSN:					
		EMPLOYER		EMPLOYER PHONE	EXTENSION				
		EMPLOYER ADDRESS		CITY	STATE	ZIP			
INSURANCE	List all insurances for which you have a current card. List Medicaid second if you have primary insurance.	PRIMARY (FIRST) INSURANCE NAME		EFFECTIVE DATE	INSURANCE #1 PHONE				
		INSURANCE #1 ADDRESS							
		POLICY HOLDER LAST NAME		FIRST NAME:	RELATIONSHIP:				
		(IF SAGAMORE) LIST ROUTING CODE		GROUP NUMBER:	MEMER ID:				
		SECONDARY INSURANCE NAME		EFFECTIVE DATE	INSURANCE #2 PHONE				
		INSURANCE #2 ADDRESS							
		POLICY HOLDER LAST NAME		FIRST NAME:	RELATIONSHIP:				
		IF SAGAMORE ROUTING CODE		GROUP NUMBER:	MEMER ID:				
	Spouse, step-parent, significant other living with you	NAME		RELATIONSHIP					
		DATE OF BIRTH		SSN:					
		CELL PHONE		EMPLOYER:					
		EMPLOYER ADDRESS		EMPLOYER PHONE					
	Emergency Contact Relative or Friend	NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU							
		RELATIONSHIP		RELATIVE/FRIEND PHONE					
		ADDRESS							
		CITY		STATE	ZIP				

Insurance Information Form

(This information pertains to the person who carries the insurance.)

Today's Date _____/_____/_____

Insurance effective date: _____/_____/_____

Insured's Name: _____

Are you replacing previous insurance? YES NO (Please circle one)

Employer of the Insured: _____

Insured's DOB: _____/_____/_____ SSN: _____

Phone Number (w/area code): _____

List <u>all</u> children covered by this insurance. (Patients of JMH Pediatrics only)

Name (first and last)	DOB	Relationship to Insured	Primary/ Secondary

****Please give your insurance card to the receptionist to copy****

****Please inform the receptionist if you have more than one insurance****

JMH PEDIATRIC SPECIALISTS
AUTHORIZATION TO LEAVE MESSAGE

Because of new Federal privacy regulations, we must have your authorization as to where to leave messages. It is our office policy to NOT release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave a message *if* the name or telephone number is not on the recorded message to identify the residence. We may simply request that you return the call. Information will also NOT be given to any unauthorized person who may answer the telephone.

I authorize Franklin Pediatrics and/or staff to leave medical information pertaining to the care of my child(ren) by the following methods and will assume responsibility to notify them whenever this information changes. In addition to medical information, information concerning appointment confirmation, rescheduling of appointments or nurses follow-up may be left by the following methods.

Method	Number w/Area Code		
Home Telephone	_____	**Yes** _____	**No** _____
Answering Machine	_____	**Yes** _____	**No** _____
Work Telephone	_____	**Yes** _____	**No** _____
Voice Mail	_____	**Yes** _____	**No** _____
Cell Phone and/or Cell Phone Voice Mail	_____	**Yes** _____	**No** _____
Pager	_____	**Yes** _____	**No** _____
FAX	_____	**Yes** _____	**No** _____

The following individuals have my/our permission to receive medical information about my/our child(ren):

Name	**Relationship**

While my child(ren) is/are patients, should they bring in a photo or school picture, the office has your permission to display this picture on our office wall. Yes _____ No _____

If there are any changes to the above authorizations in this time period, it is the parent's responsibility to notify the office of any changes.

Child's Name: _____ **Date of Birth:** _____

Parent/Guardian: _____ **Date:** _____
(PRINTED)

Parent/Guardian: _____ **Date:** _____
(SIGNATURE)

Patient Address: _____

JMH Pediatrics

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you or your child. By completing this form you are informing us that you wish to designate the named person(s) as your or your child's personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

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

Designation:

I, _____ (print name), hereby nominate the following person(s) to act as my or my child's personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me or my child. **Our office requires a PARENT to accompany any child under the age of 18 for all New Patient, Well Child and/or Vaccination or Injection Visits.**

Please check the applicable box indicating if we may discuss your child's health status or financial (bill) matters with your selection(s) below.			Health Information	Financial (Bill)
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No

The authority of this person when acting as my personal representative is restricted to the marked functions. **Representatives may accompany a child to "sick" visits only.** JMH Pediatrics reserves the right to collect copays that are due at the time of service from the designated representative.

Guarantor Signature: _____ Date: _____
(or patient, if 18 or older)

Revocation:

I understand that by signing this Revocation Section of my copy of this form and returning it to Franklin Pediatrics, I revoke this designation. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my or my child's health information have already acted in reliance on this designation.

_____ _____
Guarantor (or patient, if 18) Signature Date

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____ DATE COMPLETED _____

BIRTH DATE _____ AGE _____ M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

_____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

_____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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