PATIENT DEMOGRAPHIC FORM

CHILD'S NAME:

Last Name: _____ First Name: _____

Date of Birth: _____ Hospital Name: _____

SIBLINGS NAMES: _____

PARENT/GUARDIAN'S INFORMATION

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Date of Birth: _____ Date of Birth: _____

Address: _____ Address: _____

City/Zip: _____ City/Zip: _____

Email: _____ Email: _____

Phone: _____ Phone: _____

Occupation: _____ Occupation: _____

EMERGENCY CONTACT (other than parent/guardian)

Name/Phone: _____ Relationship to Patient: _____

INSURANCE PLAN: _____ Name of Subscriber: _____

Member Number: _____ Relationship to Subscriber: _____

I HEREBY AUTHORIZE NEGATIVE LAB/XRAY RESULTS TO BE REPORTED TO ME VOICEMAIL/MYCHART

I UNDERSTAND THAT EAST MILTON PEDIATRICS BELIEVES STRONGLY IN THE SAFETY AND EFFICACY OF IMMUNIZATIONS AND MY CHILD WILL RECEIVE IMMUNIZATIONS AS RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS. *EAST MILTON PEDIATRICS DOES NOT* ACCEPT OR KEEP PATIENTS/FAMILIES WHO REFUSE TO VACCINATE.

I HEREBY AUTHORIZE BILLING VIA ELECTRONIC SUBMISSION AND PAYMENT DIRECTLY TO THE OFFICE FOR PROFESSIONAL SERVICES RENDERED AND I SHALL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO THIS OFFICE. CO-PAYMENTS ARE DUE AT THE TIME OF YOUR VISIT. THE OFFICE RESERVES THE RIGHT TO ADD BILLING CHARGES TO ACCOUNTS AFTER SIXTY DAYS AND ANY ACCOUNTS FORWARDED TO COLLECTION SERVICES WILL BE SUBJECTED TO AN ADDITIONAL 1/3 CHARGE ADDED TO THE ACCOUNT. I AUTHORIZE THE ATTENDING PHYSICIAN TO RELEASE INFORMATION CONCERNING THE EXAMINATION AND TREATMENT OF MY CHILD. (FOR INSURANCE PURPOSES ONLY)

I AM GRANTING PERMISSION FOR EAST MILTON PEDIATRICS TO VIEW MY CHILD'S HISTORY FROM EXTERNAL SOURCES.

I HAVE RECEIVED YOUR NOTICE OF PRIVACY PRACTICES AND/OR I HAVE BEEN *PROVIDED AN OPPORTUNITY TO REVIEW IT.*

I AGREE THAT TELEPHONE MESSAGES REGARDING MY APPOINTMENTS, PRESCRIPTION REFILLS, LAB RESULTS, AND ALL OTHER PROTECTED HEALTH INFORMATION (PHI) MAY BE LEFT FOR ME ON VOICEMAIL SYSTEMS AND ANSWERING MACHINE AT THE TELEPHONE NUMBERS I PROVIDED TO YOU.

PLEASE BE SURE TO ADD YOUR CHILD TO YOUR INSURANCE PLAN. THEY WILL NOT AUTOMATICALLY DO IT WITHOUT A CALL FROM THE SUBSCRIBER. THANK YOU!

SIGNATURE: _____ *DATE:* _____

Please complete this family history form for your child

Patient's Name: _____ Today's Date: _____

Put an X for all of **your child's** biological relatives who have the condition.

CONDITION	Child's Mother	Child's Father	Child's Sister	Child's Brother	Child's Grandmother (Mother's side)	Child's Grandfather (Mother's side)	Child's Grandmother (Father's side)	Child's Grandfather (Father's side)	Child's Aunt(s)	Child's Uncle(s)	Child's Cousin(s)
ADHD/ADD											
Asthma											
Autism spectrum disorder, PDD-NOS, Asperger's											
Birth Defect											
Bleeding or clotting disorder											
Cancer before age 50											
Born with an eye/vision problem											
Born with hearing loss											
Born with a heart problem											
Diabetes											
Early heart disease (<55 in men, <65 in women)											
Genetic syndrome or condition											
High blood pressure											
High cholesterol or triglycerides											
Kidney Disease											
Mental or mood disorder											
Obesity											
Seizures											
Sudden cardiac death											
Other condition that affects 2 or more family members											
Does not have any of the conditions listed above											
No information about this relative											

Comments:

Do you have any other concerns about your child's family health history?

Any suggestions?_____