Children's of Alabama

North Alabama Children's Specialists

Please print and complete entire form

Patient's Name: _____ **Male/ Female** **Date of Birth:**_____

Please check- Race: ___ American Indian/Alaska Native ___Blk/African American ___ Nat Hawaiian/Pacific Islander ___Asian ___ White ___ Other ___ Declined

Please Check- Ethnicity: ___Declined ___Hispanic/Latino ___Not Hispanic/Latino

Please Check-Primary Language: ___English ___Spanish ___Other:_____

Patient Resides With: ___Mother ___Father ___Other:_____

Pharmacy Name:_____**Address:**_____

Mother/Guardian:_____
Date of Birth: _____
Primary Language: _____
Email address:_____
Mailing Address: _____
City _____State_____Zip_____
Primary Phone # ( )_____
Alt Phone # ( )_____

Father/Guardian: _____
Date of Birth: _____
Primary Language: _____
Email address: _____
Mailing Address: _____
City _____State_____Zip_____
Primary Phone # ( ) _____
Alt Phone # ( ) _____

Primary Insurance Co. _____
Owner of Policy_____
Owner Date of Birth_____
Relationship to Patient_____
Policy Number_____
Group Number _____
Effective date _____
Co-Pay _____

Secondary Insurance Co._____
Owner of Policy_____
Owner Date of Birth_____
Relationship to Patient_____
Policy Number_____
Group Number _____
Effective date _____
Co-Pay _____

Primary Care Physician:_____**Phone: ( )**_____

Emergency Contact: _____ Relationship to patient _____
Primary Phone#( ) _____Alt Phone # ( )_____

PLEASE READ THE FOLLOWING VERY CAREFULLY

Consent for treatment: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates, or assistants. I understand PBM, Prescription Benefits, will be checked in order to ensure prescription fill history.
Authorization for release of medical records and insurance information: I hereby authorize the release of any or all medical records including psychiatric, drug alcohol, substance abuse and any and all financial and accounting records, including insurance information to referring physicians or agencies from whom the patient seeks medical care.
Assignment of benefits and guarantee of account: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all cost of collection including attorney's fees; all court cost if any.
Consent to contact for information/reminders: By supplying my phone number, email address, and any other personal contact information, I authorize North Alabama Children's Specialists to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.
Divorced Parents: In keeping with our policy that payment is due at the time service is rendered, it is the person who brings the patient to us who is responsible for payment and who should sign as responsible party.

Date: _____ **Responsible Party's Signature** _____

Children's
of Alabama

North Alabama Children's Specialists, 502 Governors DR SW, Huntsville, AL 35801
Phone: 256-533-0833 Fax: 256-533-0855
Dr. Martina Bebin; Dr. Gerald Judy; Dr. Vinit Mahesh

Children's of Alabama –*Annual Form*
Authorization to Release Information (Past and Future Care)

Patient Name: _____ Date of Birth:_____
(First, MI, Last)

Address:_____ Contact Phone #:_(___)_____

What information do you want to release? (examples may be a school excuse faxed)	Where do you want this information to be sent? (examples may be Huntsville High School, Regions)
___ANY and All information OR *ONLY* ___Work/School Excuses ___Medication Lists/Health Information ___Medical History/Physical Exam (example: sports) ___Physician Orders/Visit Notes ___Other:_____ ___ I would like to receive email appt. reminders _____ Email Address ___I would like to receive text appt reminders ___ Form Declined	Please print list of locations: _____ _____ _____ With whom in the family may we discuss medical information about you/your child? Name: _____ Date of Birth: _____ Phone#_____ Relationship:_____ Name: _____Date of Birth_____ Phone#: _____Relationship:_____ Name: _____Date of Birth: _____ Phone#: _____Relationship:_____
HIV, Behavioral Health/Psychiatric, and Drug and Alcohol treatment information contained in the parts of the record(s) indicated above will ONLY be released when indicated by your initials below. Please initial if you authorize North Alabama Children's Specialists to release this information: *□ ___ HIV □ ___ Behavioral Health/Psychiatric* *□ ___ Drug & Alcohol*	

I authorize North Alabama Children's Specialists and its employees/physicians to release the information stated above. I understand this authorization is voluntary and for my own convenience. I understand North Alabama Children's Specialists will release only those items indicated by me unless there is a medical emergency. The health record(s) released by North Alabama Children's Specialists may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) North Alabama Children's Specialists and its employees/physicians have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the HIPAA Privacy Rule. This Authorization is in effect for a period of **one year** from the date my signature unless a shorter time frame is documented. I have the right to revoke/change my mind about this Authorization form at any time by sending a written request to the Practice Manager at the Practice Address above. My decision to revoke the Authorization does not apply to any release of my child's health record(s) that may have taken place prior to the date of my request to revoke the Authorization.

_____ _____ _____
Patient/Parent/Guardian Print Name Patient/Parent/Guardian Signature date

_____ _____ _____
Patient Signature if adult (ie: 19 or older) Witness for Patient/Parent/Guardian date

Children's
of Alabama

North Alabama Children's Specialist

Statement of Financial Policy

Our primary interest at NACS is in taking care of your child. However, we must enforce our financial policy in order to continue to provide your child the best care possible. By signing as responsible party you are acknowledging the following statement.

Demographic Updates/Responsible Party

Please, notify our front office staff if there are any changes to your insurance policy, address, and/or phone number. In order to maintain current records we require that the responsible party complete and sign a demographic form **annually**. The person who brings the child for treatment and signs the paperwork is the responsible party. In circumstances where parents are separated or divorced, NACS will not act as a mediator in collecting payment.

Insurance

We will accept and file claims with any insurance carrier with whom we are a participating provider. As a courtesy to our patients we will also file claims with non-participating carriers. Filing a claim does not guarantee payment. It is the responsibility of the cardholder to know what their eligibility and coverage is. If this is not known it is the cardholder's responsibility to verify coverage limitations prior to the appointment date.

Payment Arrangements/Past Due Accounts

Please call our Business Office if you have questions regarding your account balance. Payment arrangements can be arranged if needed. Statements are mailed monthly. If your account balance becomes past due, appropriate action will be taken to collect the amount due. Accounts that are overdue more than 90 days will be turned over to a collection agency. At that point, you will be responsible to pay the account directly to the collection agency and any fees due to them.

Referrals

It is your responsibility to ensure that all necessary referrals from the correct assigned Primary Medical Provider are in place. Some insurance companies including Medicaid will not pay for specialized services without a referral. Any payment denied for lack of referral will be forwarded to the responsible party for payment.

Non-Covered Services & Additional Charges

No Show Appointments

There is a $25 fee for all "no show" appointments-no exceptions. As a courtesy we provide an appointment reminder slip at check out and a call reminder three days before your appointment. Although our office provides these reminders for you; it is ultimately your responsibility to inform the office of cancellations/reschedules with-in 24 hours during business hours to avoid being considered a "no show." More than two no shows annually may result in dismissal from the practice.

Processing Fee

Copays/coinsurance, deductibles, and non-covered services are due in full and payable at the time service is rendered. A $10 processing fee will be charged to your account if payment is not made at the time of service.

Forms

A $5.00 form fee will be charged for all forms requested outside of an office visit. Allow 48 hours for your request to be processed. There is no charge for work/school excuses. Please remember to request this at check-out.

Medical Records

Please contact Medical Records for all requests.

Returned Checks

There is a $25 fee for all returned checks.

In order to protect the privacy of our patients we do not fax forms.
Forms can be mailed to your home address if the form fee has been paid.

I have read and received a copy of the Statement of Financial Policy and The Privacy Policy.

_____
Patient Name

_____
Parent/Responsible Party signature & Date

Children's
of Alabama

Children's of Alabama
1600 7th Avenue South
Birmingham, AL 35233
(205) 638-9100

CHILDREN'S OF ALABAMA
NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Child's Privacy Is Important to Us
Children's of Alabama (Children's) is committed to respect patient privacy and protect confidential patient information. **This Notice of Privacy Practices (Notice) describes your child's privacy rights and explains the ways in which we may share your child's health information (called "Protected Health Information"-PHI or electronic PHI) with others.**

If you do not understand the terms of this Notice, please ask for further explanation. This Notice is required under the healthcare federal privacy law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Omnibus Regulations.

Who Will Follow This Notice
This Notice applies to all records of your child's care generated by The Children's Hospital of Alabama, doing business as Children's of Alabama (Children's). This Notice describes the practices of Children's (including its Russell Campus, clinics, outpatient surgery center, primary and specialty care offices, and foundation) and its healthcare professionals, employees, medical staff, students, and other authorized individuals and companies with each other for treatment, payment, or healthcare operations purposes described in this Notice.

Our Privacy Pledge to You and Your Child
We understand that health information about your child is personal and must be properly safeguarded. Children's pledges to use or disclose your child's health information as required or permitted by law. We promise to respect your child's privacy rights and comply with all applicable privacy laws, including but not limited to The HIPAA Omnibus Regulations for safeguards of electronic health information and any notification data breaches as set forth in HIPAA Omnibus. **This means you have a right to notice from Children's in event of a data breach as mandated by law. You would receive this notice from Children's only if you were to have a breach of unsecured protected health information**

Your Child's Privacy Rights
Although your child's medical record is the physical property of Children's, the information belongs to you as the parent/legal guardian.
At Children's, you have the right to:

- *Ask that we limit how we use and disclose your child's health information.* You have the right to request in writing a restriction of your child's health information. You may not be able to limit the uses and disclosures required by law or if the information is needed to provide your child emergency treatment.
- *Right to request that health information pertaining to services paid out of pocket not be sent to insurance.* In some instances, you may choose to pay for a healthcare item or service out of pocket, rather than submit a claim to your insurance company. You have the right to request that we not submit your child's health information to a health plan or your insurance company, if you, or someone on your behalf, pay for the treatment or service out of pocket in full. To request this restriction, you must make your request in writing on the required form to the Privacy Officer PRIOR to the treatment or service. In your request, you must tell us (1) what information you want to restrict and (2) and to what health plan the restriction applies.
- *Choose how we send your child's health information to you.* You have the right to request in writing for your child's health information to be sent by different means or to different locations (i.e., only to work address, fax instead of mail). We must agree to your request if we can reasonably meet it.
- *Right to inspect and receive copies of your child's health information.* You have the right to request in writing to inspect and

receive copies of your child's health information (i.e., paper or electronic if required). Usually, this includes medical and billing records, but does not include psychotherapy notes. There will be charges for the copies, mailing, or other supplies associated with your request. Please allow 14 days to process your request. If we are not able to meet your request, we will send you our reason in writing and you can request a review of the denial. Another physician chosen by Children's will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- *Receive a list of the instances in which we have disclosed your child's health information.* You have the right to request in writing a record of certain disclosures ("accounting of disclosures") of your child's health information. There may be restrictions that apply.
- *Amend your child's health information.* You have the right to request in writing that we amend your child's health information if you feel the information is incomplete or incorrect. You must also provide the reason. If we are not able to meet your request, we will send you our reason in writing and you can request a review.
- *Request a paper copy of this Notice at any time.* You have the right to request a paper copy of this Notice at any time. You can also obtain a copy of our Notice at the Children's internet web site http://www.childrensal.org.
- *Revoke your authorization to use or disclose your child's health information.* You have the right to revoke or take away your authorization in writing, except to the extent action has already been taken on it.

Please let us know how we can help. To make a written request to exercise these rights, forms are available in Medical Information Services at the Russell Campus, with the Practice Managers in the Children's owned practices and with the Children's Privacy Officer. The Privacy Officer and your Patient Registration, Medical Information Services, and Patient Relations team are some of the experts to serve you.

Examples of How We Will Use and Disclose Your Child's Health Information

For Treatment and Treatment Alternatives: We will use and disclose your child's health information recorded by a nurse, physician, or other member of your child's healthcare team or other healthcare practitioners to determine the best course of treatment for your child. This will also enable your child's healthcare team to coordinate care and review the treatment your child has received and how your child is responding. Information may also be mailed, faxed, auto-faxed, sent by text and e-mailed to you and the healthcare team as appropriate. We also may disclose medical information about you to people outside Children's who may be involved in your medical care after you leave, such as your local physician, family members, clergy or others we use to provide services that are part of your care. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Payment: We will use and disclose your child's health information for payment purposes, such as sending a bill to you or your insurance company with information that identifies your child. You have the right to request to restrict disclosures to your payors/insurance company for services paid as out of pocket in full for the health care item or service.

Health Information Exchanges: Children's may participate in health information exchanges to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each of us can provide better treatment and coordination of your healthcare services. In addition, your child's health information may be available to other clinicians and staff who may use it to care for you, to coordinate your health services or for other permitted purposes.

Healthcare Operations: We will use and disclose your child's health information to assess care during your child's visit and to carry out routine business functions, such as accreditation reviews and improving healthcare services. Children's may evaluate my or my child's health information related to the treatment, hospitalization, outpatient care, or other processes as part of its quality improvement efforts. Quality improvement is designed to apply knowledge or assess a process or program with the goal of improving that activity, process, system, or outcome.

Examples of How We May Use and Disclose Your Child's Health Information

Appointment Reminders and Follow-Up: We may use and disclose your child's health information to contact you for your child's appointment reminder or to follow-up after a visit. This may be verbal, written, or electronic (such as by email, text). We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

Treatment Options and Health-Related Benefits: We may use and disclose your child's health information while discussing with you possible treatment options, alternatives and health-related benefits for your child, including internal and community healthcare resources, benefits, and programs.

Individuals Involved in Your Care or Payment for Your Care. We may release health information about your child to a friend or family member who is involved in your child's medical care. We may also give information to someone who helps pay for your child's care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

As Required or Permitted by Law: We may use and disclose your child's health information when required or permitted by

federal, state, or local law, including specific government functions.

Business Associates: There are some services provided in Children's through contracts with business associates. Examples include consultants, medical transcriptionists, and third-party billing companies. We may use and disclose your child's health information to our Business Associates to enable them to perform the job we asked them to do. They must appropriately safeguard your child's health information.

For Public Health and Safety: We may use and disclose your child's health information as appropriate to a health oversight agency or individual charged with controlling disease, injury, or disability or preventing a risk to public health and safety. For example, we are required to report the existence of a communicable disease, such as tuberculosis, to the Alabama Department of Public Health to protect the health and well-being of the general public. We may disclose health information about your child to individuals exposed to a communicable disease or otherwise at risk for spreading the disease. We may disclose medical information to an employer if the employer requires the healthcare services to determine whether your child has a work-related injury.

Food and Drug Administration (FDA): We may disclose to the FDA and to manufacturers health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement,.

Victims of Abuse, Neglect, or Domestic Violence: We are required to report child, elder, and domestic abuse or neglect to the State of Alabama, such as the State of Alabama Department of Human Resources (DHR).

Health Oversight Activities: We may use and disclose your child's health information to a health oversight agency for activities authorized by law. These oversight activities, include for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your child's health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may disclose medical information for judicial or administrative proceedings, as required by law.

Law Enforcement: We may release your child's health information for law enforcement purposes as required by law, in response to a valid subpoena, for identification and location of fugitives, witnesses, or missing persons, for suspected victims of crime, for deaths that may have resulted from criminal conduct and for suspected crimes on the premises.

Coroners, Medical Examiners, and Funeral Directors: We may release your child's health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation: If your child is an organ donor, we may use or release health information to organizations that handle organ procurement or other entities engaged in procurement, banking, or transportation of organ, eye, or tissue to facilitate organ or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about your child when necessary to prevent a serious threat to your child's health or safety and the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If your child is a member of the armed forces, we may release health information about your child as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

National Security and Intelligence Activities. We may release medical information about your child to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may release health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Worker's Compensation. We may release medical information about your child for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Inmates or Individuals in Custody. If your child is an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about your child to the correctional institution or law enforcement official.

Research: We may use and disclose your child's health information as authorized by Children's or Children's approved Institutional Review Board in accordance with protocols to ensure your child's privacy. Some research studies require specific patient consent, while others do not require patient authorization.

Fundraising: We may use and disclose your child's health information for marketing or to solicit funds to benefit Children's and its foundation. You may be contacted for fundraising purposes and you have a right to opt-out/decline. This is voluntary and does not affect your care or your bills for services, If you do not want Children's to contact you for fundraising efforts, you must notify the Children's Foundation at Andrea.Martin@Childrensal.org or (205) 638-9017. You may also contact the Privacy Officer to receive a pre-printed, pre-paid postcard to opt-out of Fundraising communications.

Certain Marketing Activities: Children's may use health information about your child to forward promotional gifts of nominal

value, to communicate with you about services offered by Children's, to communicate with you about treatment alternatives. We do not sell your health information to any third party for their marketing activity.

Registration and Waiting Areas: We may disclose your child's health information on registration/sign-in sheets, by calling out to facilitate services in waiting rooms, and during the overhead paging process.

Whiteboards/Electronic Boards. We may disclose your child's health information on whiteboards/electronic boards to facilitate patient care, which may be publicly visible in the patient care area.

Other uses and disclosures: We will obtain your authorization to use or disclose your child's psychotherapy notes (other than for uses permitted by law without your authorization); to use or disclose your health information for marketing activities not described above; and prior to selling your child's health information to any third party. Any uses and disclosures not described in this Notice will be made only with your written authorization.

When You Will Have the Opportunity to Object:

Patient Directory Information for Hospital Inpatients: Unless you notify Patient Registration that you object, we may release certain limited information about your child from the patient directory, such as your child's name, location in the hospital, general condition (i.e, fair, stable), or religious affiliation (shared only with the clergy). The information may be provided to people who ask for your child by name (including the press/media). This will allow your family, friends, and clergy to visit and learn of your child's condition and for deliveries to be made to your child.

Notification: For minor patients, we may use or disclose health information to a parent or legal guardian. For adult patients, we may use or disclose health information to notify a family member, personal representative you have the right to assign, or another person responsible for your care. We use our professional judgment for notification under certain circumstances such as an emergency.

Other Important Considerations:

Complaints: If you believe your child's privacy rights have been violated, please contact your Children's Patient Relations Representative as soon as possible: Patient Relations, Children's of Alabama, 1600 7th Avenue South, Birmingham, AL 35233, Phone (205) 638-3999, FAX (205) 638-3221 or go to http://www.integrity-helpline.com/childrensal.jsp.

Children's Patient Relations Department and Privacy Officer will promptly respond to your complaint.

You may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. Your child's care will never be adversely affected for filing a complaint.

Changes in Notice: We reserve the right to change this Notice and privacy practices and to make the new changes effective for all your child's health information we currently have and any we receive in the future. If our privacy practices change, we will post a copy of the revised Notice at Children's. It will also be available on the Children's web site. This Notice is effective immediately and supercedes original notice that was effective April 14, 2003. You have a right to receive a current copy of the notice upon your request.

Other Uses of Your Child's Health Information: We will not use or disclose your child's health information, without your permission/authorization, except as described in this Notice or as required by law. You may authorize disclosure for other purposes by completing a written authorization that meets the requirements of the law. You may revoke such authorization in writing at any time and it will be effective upon receipt as allowed by law.

For more information: Please contact Privacy Officer, Children's of Alabama
1600 7th Avenue South, Birmingham, AL 35233, HIPAA@Childrensal.org; Phone (205) 638-5959, FAX (205) 638-2468

If you need an interpreter you may ask an employee at the desk.
Children's of Alabama will provide an interpreter at no cost to you.
Si usted necesita un interprete, solicitelo al empleado que se encuentra en el mostrador.
El Hospital de Ninos le proveera un interprete sin costo alguno.

Children's
of Alabama
North Alabama Children's Specialist

Statement of Financial Policy

Our primary interest at NACS is in taking care of your child. However, we must enforce our financial policy in order to continue to provide your child the best care possible. By signing as responsible party you are acknowledging the following statement.

I have read the Statement of Financial Policy. I understand and agree to the policy.

Methods of Payment
We accept cash, personal checks, and credit/debit cards (MasterCard, Visa, and Discover).

Demographic Updates/Responsible Party
Please, notify our front office staff if there are any changes to your insurance policy, address, and/or phone number. In order to maintain current records we require that the responsible party complete and sign a demographic form **annually**. The person who brings the child for treatment and signs the paperwork is the responsible party. In circumstances where parents are separated or divorced, NACS will not act as a mediator in collecting payment.

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NEW PATIENT QUESTIONNAIRE

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

_____

Patient Home Phone: _____ Primary Caretaker Cell Phone: _____

Primary Caretaker Work Phone: _____ Fax: _____

Primary Caretaker Email Address: _____

Date of Clinic Visit: _____

Name and Relationship of Person Completing Questionnaire:

_____

Signed: _____ Date: _____

PLEASE CHECK WITH YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT TO ENSURE THAT ALL MEDICAL RECORDS HAVE BEEN SENT TO OUR OFFICE; PLEASE BRING ACTUAL EEGS, CT'S, AND MRI's ON DISK

Patient's age:
Is your child left- or right-handed, ambidextrous (both), or neither?
Is there a history of any of the following before the onset of seizures: Brain infections (including meningitis, encephalitis), head injuries, or problems with the patient's birth history (or the mother's pregnancy)?

Questions you wish to have answered (i.e., your goals for this visit). Please list the most important questions you would like answered at this visit.

What signs or symptoms is your child experiencing?

How long have these symptoms been present?

What part(s) of the body and what functions are affected?

How often do these symptoms occur (daily, weekly, monthly)? Please describe the duration of the symptoms (minutes, hours):

Do these symptoms occur at a particular time of day? Is so, when?

Does anything make the symptoms get better? If so, what?

Does anything make the symptoms get worse? If so, what?

Has there been prior treatment (i.e., medications) or surgery for this problem? If so:

What type of treatment?

What was the result of treatment?

Please describe all other current medical problems and past medical illnesses:

Please list all past surgical procedures with estimated dates:

_____

_____

_____

Please list any current medications including doses and times given:

_____

_____

_____

_____

Does the patient have any allergies to medications? Yes ☐ No ☐ If yes, please list the medication and the nature of the reaction.

_____

_____

_____

Birth History:

What was the patient's birth weight? _____ lbs _____oz
Was the patient born prematurely? Yes ☐ No ☐
If yes, how many weeks premature? _____
Was the patient born by Caesarian section ("C-section")? _____
Were there any problems during pregnancy? Yes ☐ No ☐ If yes, please describe:

_____

_____

_____

Were there any problems during delivery? Yes ☐ No ☐ If yes, please describe:

_____

_____

_____

Did the patient have any problems in the newborn period(first month of life)? Yes ☐ No ☐ If yes, please describe:

_____

_____

_____

How long did your child stay in the hospital after birth? _____

Developmental History:

Have you ever had any worries about normal or slow development in your child? Yes ☐ No ☐ If yes, please describe at what age you first became concerned and what symptom(s) made you worry about development:

_____

_____

_____

Has your child ever lost developmental skills? Yes ☐ No ☐ If yes, please describe at what age the skills were lost, and which skills were lost:

_____

_____

_____

Has your child been given any diagnosis of a specific developmental problem or handicapping condition (for example, cerebral palsy, learning disability)? Yes ☐ No ☐ If yes, please describe:

_____

_____

_____

Does your child receive any specialized developmental treatment services or special education program (for example, physical therapy or special classroom placement)? Yes ☐ No ☐ If yes please describe:

_____

_____

What is your child's current educational placement (school, grade level)?

_____

_____

Family History:

Please list illnesses that affect other members of the patient's family:
Patient's Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Patient's Father: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Patient's Brother(s): _____

_____

Patient's Sister(s): _____

_____

Do any of above family members, or more distant relatives, have any known seizure conditions? Yes ☐ No ☐ If yes, please describe:

_____

_____

_____

Social History:
Please describe the patient's current living arrangements (i.e., who lives in the home, and who provides primary childcare):

_____

_____

_____

Review of systems: Please check any symptom, condition or problems in the areas listed below, and describe details of the problems if present in patient.

REVIEW OF SYSTEMS - GENERAL			
GENERAL HEALTH	**EARS, NOSE, MOUTH, THROAT**	**CARDIOVASCULAR**	**BLOOD/ENDOCRINE**
☐ Altered taste/ smell	☐ Balance problem	☐ Chest palpitations	☐ Blood disorder
☐ Change in appetite	☐ Dizziness	☐ Chest pain	☐ Sickle Cell Disease
☐ Weight loss or gain	☐ Ringing in ears	☐ Chest pressure	☐ Enlarged lymph nodes
☐ Unable to sleep	☐ Hearing loss	☐ Fainting	☐ HIV exposure
☐ Excessive sleepiness	☐ Trouble breathing through nose	☐ Heart Failure	☐ Thyroid Disease
☐ Fatigue	☐ Nose bleeds / discharge	☐ Heart Murmur	☐ Diabetes
☐ Recurrent fevers	☐ Sinus disease	☐ High blood pressure	☐ Weak bones
☐ Feeding problems	☐ Mouth sores	☐ Low blood pressure	☐ Growth problems
☐ Toilet training problems	☐ Sore throat	☐ Shortness of breath	
☐ Food intolerance	☐ Trouble swallowing	☐ Leg swelling	
MUSCULOSKELETAL	**EYES**	**GASTROINTESTINAL**	**RESPIRATORY**
☐ Low back pain	☐ Blurred vision	☐ Abdominal pain	☐ Bronchitis
☐ Neck pain	☐ Double vision	☐ Constipation	☐ Wheezing
☐ Joint pain	☐ Glaucoma	☐ Diarrhea	☐ Pneumonia
☐ Joint swelling	☐ Cataracts	☐ Gastritis	☐ Tuberculosis
☐ Broken bones	☐ Decreased vision	☐ Liver disease/hepatitis	☐ Chronic cough
SKIN	**PSYCHIATRIC**	Colic	**URINARY**
☐ Rashes	☐ Anxiety	☐ Bloody stools	☐ Increased frequency
☐ Hair problems	☐ Depression	☐ Ulcer	☐ Kidney stones
☐ Nail problems	☐ Attention problems	☐ Vomiting	☐ Bloody urine
REVIEW OF SYSTEMS – NEUROLOGIC			
☐ Confusion	☐ Clumsiness	☐ Choking	☐ Behavior/emotional
☐ Spells	☐ Facial numbness / tingling	☐ Difficulty chewing	☐ Withdrawn
☐ Dizziness	☐ Numbness - arms (L/ R/ B)	☐ Difficulty tasting	☐ Aggressive
☐ Hallucinations	☐ Numbness - legs (L/ R/ B)	☐ Drooling	☐ Hyperactivity
☐ Headache	☐ Abnormal movements	☐ Hoarseness	☐ Mood swings
☐ Sleepiness	☐ Poor coordination	☐ Incontinence- bowel	☐ Temper tantrums
☐ Memory problems	☐ Speech difficulty	☐ Incontinence- bladder	☐ Breatholding spells
☐ Personality change	☐ Stiffness	☐ Nausea	☐ Suicidal thoughts
☐ Abnormal head size	☐ Trouble walking	☐ Pain	
☐ Abnormal head shape	☐ Weakness - arms (L/ R/ B)		
☐ Trouble concentrating	☐ Weakness - legs (L/ R/ B)	☐ Snoring	

Other symptoms: (please describe)