

WELCOME TO OUR PRACTICE

Carlisle Pediatric Associates welcomes you to our practice. We provide primary care for all children, teens, and young adults.

We will act as advocates for your child's health, providing them with excellent care based on current scientific knowledge, national recommendations, and our experience.

Our goal is for you to ask questions, understand our recommendations, and leave our office comfortable with the plan of care for your child.

Office Hours

Our regular office hours are 8am to 5pm Monday through Friday.

Saturday mornings our phones are answered starting at 7:30am to schedule sick call appointments. We see patients from 8:30am until 10:30 am.

Sunday hours are from 12:30pm to 1:30pm and our phones are answered starting at 11:30am to schedule a sick call.

Holidays we are here at 10am for a short time to see walk-in sick calls.

We are closed on Thanksgiving and Christmas.

Office telephone number

717-243-1943

Our practice website

www.carlislepediatric.com

PRIMARY CONTACT PERSON FOR FAMILY (this will be the person to receive appointment reminders)

Name: _____ Home Phone: _____ Cell Phone: _____
Address: _____ Work Phone: _____ Email: _____
City: _____ State: _____ Zip: _____ Birth Date: ____/____/____
Do you live with the patient? ___ Yes ___ No Name of Employer: _____
Relationship to patient: _____

SECONDARY CONTACT PERSON FOR FAMILY- (if does not have legal custody), are authorized to (check all that apply)

___ bring child/children to appointments ___ give consent for medical care ___ give consent for age-appropriate vaccines
recommended by the American Academy of Pediatrics

Name: _____ Home Phone: _____ Cell Phone: _____
Address: _____ Work Phone: _____ Email: _____
City: _____ State: _____ Zip: _____ Birth Date: ____/____/____
Do you live with patient? ___ Yes ___ No Name of Employer: _____
Relationship to patient: _____

WHO HAS PRIMARY PHYSICAL CUSTODY? (if applicable) _____

EMERGENCY CONTACT PERSON (other than either the parent(s) or contact(s) listed above)

Name: _____ Relationship to Patient: _____ Phone: _____

LIST ONLY CHILDREN IN FAMILY THAT THE ABOVE PARENTAL INFORMATION APPLIES TO

(If children have a different family dynamic, then above - they must be on a different sheet)

	First Child	Second Child	Third Child	Fourth Child
First Name				
Middle Name				
Last Name				
Sex	___ Male ___ Female	___ Male ___ Female	___ Male ___ Female	___ Male ___ Female
Birth Date	____/____/____	____/____/____	____/____/____	____/____/____
Primary Language Spoken	___ English ___ Spanish List other: _____	___ English ___ Spanish List other: _____	___ English ___ Spanish List other: _____	___ English ___ Spanish List other: _____
Ethnicity	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown
Race	___ Native American ___ Black ___ Asian ___ White List Other: _____	___ Native American ___ Black ___ Asian ___ White List Other: _____	___ Native American ___ Black ___ Asian ___ White List Other: _____	___ Native American ___ Black ___ Asian ___ White List Other: _____



NEW PATIENT MEDICAL HISTORY

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE 1ST VISIT

*** WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES ***

The following is **very important** to your child's health. Please complete it **accurately** and **completely**.

Child's name: _____ **Birth date:** ____/____/____

Where was your child born? _____ Is child adopted or fostered? Y____ N____

Has your child **ever** previously been seen by any of the doctors **in this practice**? Y____ N____

BIRTH HISTORY

Birth Weight:	lbs.	oz.	Vaginal birth?	C-section?
Was the baby: (circle one)	Full term	Early	Late	
If early, how many weeks gestation?				
Did the baby have any problems right after birth?				
Did mother have any problems with the pregnancy?				

DEVELOPMENTAL HISTORY

	No	Yes	If Yes - explain
Are you concerned about your child's physical development?			
Are you concerned about your child's attention span?			
Has he/she failed or repeated a grade?			
How is your child's behavior in school?			
What kind of grades does he/she make in academic subjects?			
Is he/she in a special or resource classes?			
When did your child:	Sit up	mos.	Crawl
			mos.
			Walk
			mos.
First sentence (age)	Toilet trained (age)		

PATIENT ALLERGIES

	No	Yes	If YES - explain
Does this child have any known Drug Allergies ?			
If you answered YES - Is your child allergic to:			
Penicillin (Amoxicillin, Augmentin)			
Cephalosporins (Omnicef, Keflex, Rocephin, Ceclor, Suprax)			
Sulpha (Septra/Bactrim)			
Zithromax/erythromycin			
Other Antibiotics or medications? Give name:			Reaction:
Peanuts or other nuts – Give name or Group:			Reaction:
Milk			
Eggs			
Seafood			
Other Foods – give name here:			Reaction:
Bees / Wasps			
Indoor Allergens (pets, molds, dust)			
Outdoor Allergens (trees, weeds, pollens)			
Latex			
Other Allergies:			Name:

PATIENT SOCIAL HISTORY

	No	Yes	
Does patient live with both mother and father in same house?			
Non-intact home - explain custody status.			Lives with:
Does non-custodial parent have visitation rights?			
Are there Siblings?			Live in same house?
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			

PATIENT - PAST MEDICAL HISTORY	No	Yes	If Yes – explain
Serious accidents or injuries			
Surgeries			
Hospitalizations			
Chicken Pox Disease			What age:
Frequent ear infections or sinus infections			
Frequent sore throats or tonsillitis			
Other infection illnesses			
Allergic rhinitis or other allergy			
Asthma, bronchitis, bronchiolitis, pneumonia or croup			
Heart problems or heart murmur			
Abdominal pain/reflux			
Constipation requiring doctor visits			
Bladder or kidney infection or other urologic problem			
Bed-wetting (after age 5)			
Eye conditions / wear corrective lenses			
Problems with ears or hearing			
Chronic or recurrent skin problems/ acne			
Anemia or bleeding problem			
Past blood transfusion			
Frequent headaches			
Convulsions, seizures, or past concussions?			
Mental health concerns			
Seizures, developmental delays, ADD/ADHD or other neurological disorders			
Orthopedic problems			
Diabetes			
Thyroid, diabetes or other endocrine problems			
If female, have menstrual periods started?			
If female, any problems with periods?			
Use of alcohol or drugs			
Emotional or mental health problems			
Other significant issues:			

Current Medications and Dosage: (include any over the counter, herbal, or supplements)

Does your child see any specialists? If so, who and where?

In this **FAMILY** medical history – if you answer **YES** – please check off which **BIOLOGICAL RELATIVE** has the condition
 Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather
 List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	NO	YES	If YES - Please check which biological relative							
			Mom	Dad	Sib	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth	
Nasal allergies or other allergies										
Asthma/lung disease										
Heart disease or heart condition										
High blood pressure										
High cholesterol										
Diabetes or other endocrine problem										
Cancer										
Anemia										
Bleeding disorders										
Epilepsy or convulsions										
Intellectual Disability or Developmental Disorder										
Neurological disorder including ADHD/ADD										
Liver disease										
Other GI disease / disorder										
Kidney disease										
Bed-wetting (after age 10)										
Hearing impairment										
Vision impairment or eye disorder										
Immune problems, recurrent infections or HIV-AIDS										
Alcohol Abuse										
Drug Abuse										
Mental Illness										
Tuberculosis										
Other issues:										

Is there anything else regarding your child's health that you think we should know that has not already been asked?

**WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES
 THIS FORM MUST BE COMPLETED AND RETURNED BEFORE 1ST VISIT**

I understand that providing correct and complete information is essential to my child's health, and that incomplete or incorrect information can be dangerous. It is my responsibility to inform the office of any changes in my child's family or medical history after I have submitted this form.

Signature _____

Relationship to patient _____

_____/_____/_____
 Date

Print Name _____

Carlisle Pediatric Associates, P.C.

AUTHORIZATION TO INITIATE AND APPROVE MEDICAL CARE IN MY ABSENCE

I am the child's biological or adoptive parent or legal guardian.

I HEREBY AUTHORIZE THE PERSON(S) LISTED BELOW TO: (please check boxes)

☐ Bring the child/children to appointments

☐ Give consent for medical care for my child/children in my absence. This person will be authorized to discuss my child's medical information, authorize medical decisions on my part, consent for any treatment recommended by the provider, and give consent for tests to be done as deemed necessary by the provider (in office tests and tests which may get sent out to an outside lab).

☐ Give consent for all age-appropriate vaccines which are recommended by the AAP (including seasonal flu vaccine, HPV, and COVID).

PRINT name of authorized person: _____

Relationship to patient: _____

PRINT name of authorized person: _____

Relationship to patient: _____

PRINT name of authorized person: _____

Relationship to patient: _____

List all patients' names and birthdates to which this applies:

Patient: _____ Date of Birth: ____/____/____

Patient: _____ Date of Birth: ____/____/____

Patient: _____ Date of Birth: ____/____/____

Patient: _____ Date of Birth: ____/____/____

Patient: _____ Date of Birth: ____/____/____

PRINTED Name : _____

SIGNATURE: _____

Today's Date: ____/____/____

We understand you can't always attend appointments but there are times we need to contact you during the appointment.

PLEASE list a contact phone number you can be reached at during appointments: _____ - _____ - _____

**** I understand unless their parental rights have been terminated either through a court order or through the adoption process, both biological parents have access to their child's medical information. Each biological parent can authorize someone to bring their child to their appointments in their absence. The other parents cannot override this authorization.**

**** This authorization will remain in effect until the person completing the forms makes changes to the names listed above.**

**** IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT, YOU MAY BE CONSIDERED SELF-PAY****

Medical Assistance Coverage: Highmark Wholecare YES ____ NO

If you have medical assistance, you must complete yearly DPW forms to maintain your coverage. If not completed, you may be responsible for your bills.

CHIP Coverage: Name of CHIP plan (ex. Geisinger, Keystone, etc): _____

WHO CARRIES PRIMARY COMMERCIAL INSURANCE (through employer or individual plan):

Name: _____ Birth Date: ____/____/____ Best Phone # to contact you: (____)____-____

Name of Ins. Company: _____ Do you live with patient? ____Yes ____No Relationship to patient: _____

WHO CARRIES SECONDARY COMMERCIAL INSURANCE (through employer or individual plan):

Name: _____ Birth Date: ____/____/____ Best Phone # to contact you: (____)____-____

Name of Ins. Company: _____ Do you live with patient? ____Yes ____No Relationship to patient: _____

I agree with all office policies & parental responsibilities. The information is available on the office website at www.carlislepediatric.com. Our "Notice of Privacy Practices" is displayed in the office waiting room. Copies of information can be provided upon request.

SIGNATURE: _____ **RELATIONSHIP TO PATIENT:** _____ **DATE:** _____

PRINT NAME: _____