

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 Newborn- 6months

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___

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 Disorders									
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:									

SOCIAL HISTORY	No	Yes
Lives with both mother and father in same house		
Non-intact home - give 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?		
Other issues:		

Birth Weight: _____ lb _____ oz

Birth Length: _____ inches

NEWBORN HISTORY – while in hospital	No	Yes	If YES - explain
Resuscitation at delivery (needed help to start breathing/crying)			
Premature infant			
Did NOT get vitamin K and / or eye prophylaxis			
Feeding: Breast milk or formula? Or both?			
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening lab work (to check for infection)			
Elevated Bilirubin (jaundice)			
Circumcision			
Delayed passage of first bowel movement			
Heart Murmur			
Breathing problems			
Needed oxygen or help breathing			
Needed antibiotics while in nursery			
Apnea (stopping breathing)			
Needed head ultrasound			
Needed ophthalmologic (eye) exam			
Other issues:			
MOTHERS PRENATAL HISTORY	No	Yes	If Yes - explain
Was this an assisted conception (had to have help getting pregnant)?			
Was this a High-Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
Did you have little, late, or no prenatal care?			
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before born?			
Water broke more than 24 hours before delivery?			
Did you have antibiotics or other medications during labor?			
Was your labor induced (started by medications)?			
Was this delivery vaginal or by C-section?			
Was there meconium (green bowel movement) present when your water broke?			
Other Issues:			

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

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: _____