all about KIDS pediatrics

Child's Name: _____ Date of Birth:_____

Address: _____

Phone Number: _____Email address: _____

Guarantor(person responsible for account):_____Guarantor DOB:_____

Emergency Contact(someone other than Guarantor): _____

Relationship:_____ Emergency contact Phone Number: _____

How would you like to receive Appointment reminders? (Chose one option)

____ call ____ text ____email

Do we have permission to obtain your child's electronic vaccination records through Impact?

_____ yes _____no

Do we have permission to share your child's medical records with the local hospitals?

_____ yes _____no

Do we have permission to obtain your child's electronic Medication History?

_____ yes _____no

Does your child have any allergies?

_____ yes _____no If yes, please list below.

_____

_____

Please list any medications your child is currently taking:

_____

_____

What pharmacy do you regularly use?

_____

Parent Name:_____

Parent Signature: _____ Date:_____

292 BROOKS MALOTT ROAD, MOUNT ORAB, OHIO 45154

PHONE: 937-444-0035 FAX: 937-444-0036

CHILD'S LEGAL NAME: _____ **BIRTHDATE:** _____

BIRTH HISTORY:

AT WHAT HOSPITAL WAS THE CHILD BORN: _____ CITY: _____

BIRTH LENGTH: _____ BIRTH WEIGHT: _____ WAS THE CHILD BORN: VAGINAL OR C-SECTION

ANY COMPLICATIONS DURING PREGNANCY/DELIVERY? YES NO

IF THERE WERE COMPLICATIONS, PLEASE EXPLAIN: _____

WAS THE CHILD BORN WITHIN 3 WEEKS OF DUE DATE? YES NO

FOR NEWBORNS ONLY: WHAT DATE WAS HEPATITIS B INJECTION GIVEN: _____

WAS THE NEWBORN HEARING SCREEN NORMAL: YES NO

WAS THE BABY'S FOOT STUCK FOR METABOLIC SCREEN: YES NO

PREVIOUS SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS ILLNESSES:

DESCRIPTION	WHEN	WHERE

SOCIAL HISTORY:

ARE ANY MEMBERS OF THE CHILD'S HOUSEHOLD EXPOSED TO ANY CHEMICALS AT WORK? _____

DOES THE CHILD LIVE NEAR ANY FACTORIES OR PLANTS? YES NO

DOES THE PATIENT CURRENTLY LIVE IN A/AN (PLEASE CIRCLE ONE OF THE FOLLOWING):

SINGLE FAMILY HOME APARTMENT CONDOMINIUM MOBILE HOME PUBLIC HOUSING

IS THE CHILD EXPOSED TO LEAD BASED PAINT? YES NO

IS THE CHILD EXPOSED TO SECONDHAND SMOKE? YES NO

IS YOUR HOUSE SUPPLIED BY WELL WATER? YES NO

ARE THERE PETS IN THE HOME? YES NO IF SO, WHAT TYPE OF PET/S? _____

WAS THE CHILD'S HOME BUILT PRIOR TO 1978? YES NO

WHO DOES THE CHILD CURRENTLY LIVE WITH? _____

WHO DOES THE CHILD RELY ON FOR SOCIAL SUPPORT? _____

FAMILY MEDICAL HISTORY:

PLEASE NOTE IF ANY OF THE CHILD'S FAMILY MEMBERS (PARENTS, SISTERS, BROTHERS, AUNTS, UNCLES, GRANDPARENTS) HAVE ANY OF THE FOLLOWING.

TUBERCULOSIS (TB) _____

HEPATITIS _____

HIV _____

ALCOHOLISM _____

HYPERTENSION _____

HEART DISEASE < 55 YEARS _____

STROKE _____

DIABETES _____

CANCER (TYPE) _____

ANEMIA _____

ASTHMA _____

BLEEDING DISORDER_____

MIGRAINE HEADACHES _____

EPILEPSY (SEIZURES) _____

DRUG ABUSE_____

MENTAL ILLNESS _____

LUNG DISORDER_____

ALLERGIES _____

HEARING LOSS _____

LOW VISION _____

GENETIC DISEASE CARRIER _____

DEPRESSION _____

PLEASE SEE OTHER SIDE OF FORM-→

SOCIAL DETERMINANTS OF HEALTH

DOES ANYONE IN THE HOUSEHOLD NOT HAVE A HIGH SCHOOL DEGREE? YES NO

IF YES, DO THEY NEED HELP GETTING A GED? YES NO

DOES ANYONE IN THE HOUSEHOLD NOT HAVE A JOB? YES NO

IF YES, WOULD THEY LIKE HELP FINDING EMPLOYMENT? YES NO

DOES ANYONE IN THE HOUSEHOLD SMOKE CIGARETTES? YES NO

IF YES, WOULD THEY LIKE HELP TO QUIT? YES NO

DOES ANYONE IN THE HOUSEHOLD USE DRUGS? YES NO

IF YES, WOULD THEY LIKE HELP? YES NO

DOES ANYONE IN THE HOUSEHOLD HAVE A PROBLEM WITH ALCOHOL? YES NO

IF YES, WOULD THEY LIKE HELP? YES NO

ARE YOU FEELING SAD OR HOPELESS A LOT OF THE TIME? YES NO

IF YES, WOULD YOU LIKE HELP? YES NO

HAS ANYONE HIT OR VERBALLY ABUSED YOU? YES NO

IF YES, WOULD YOU LIKE HELP? YES NO

DO YOU NEED DAYCARE? YES NO

IF YES, WOULD YOU LIKE HELP FINDING IT? YES NO

ARE YOU AT RISK OF BECOMING HOMELESS? YES NO

IF YES, WOULD YOU LIKE HELP WITH THIS? YES NO

DO YOU NEED HELP IN GETTING FOOD BY THE END OF THE MONTH? YES NO

IF YES, WOULD YOU LIKE HELP WITH THIS? YES NO

FOR FEMALES, AGES 12 AND ABOVE

AGE WHEN PERIOD STARTED _____ DATE OF LAST PAP SMEAR _____ DATE OF LAST PERIOD _____

ANY CRAMPING WITH PERIODS (PLEASE CIRCLE ONE): NONE MILD SEVERE

PERIODS ARE CONSIDERED (PLEASE CIRCLE ONE): REGULAR IRREGULAR ABSENT

HISTORY OF ABNORMAL PAP SMEAR? YES NO

MENSTRUAL FLOW IS (PLEASE CIRCLE ONE): NORMAL LIGHT HEAVY ABSENT

DOES CHILD USE CONTRACEPTION? YES NO

IF USING CONTRACEPTION, WHAT FORM? _____

HISTORY OF BREAST LUMP? YES NO

IS CHILD SEXUALLY ACTIVE? UNKNOWN YES NO

NUMBER OF MISCARRIAGES _____ PREGNANCIES?_____ABORTIONS? _____ STILLBORNS?_____TWINS? _____

BREAST CANCER HISTORY IN ANY OF THE FOLLOWING (PLEASE CIRCLE ANY THAT APPLY):

SELF MOTHER SISTER GRANDMOTHER AUNT

Late Arrival Policy

Our providers, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is late/ arrives at any time after their scheduled appointment time for a well child visit, the appointment will need to be rescheduled.

If a patient is more than 10 minutes late for a sick appointment, the appointment may need to be rescheduled. This is at the provider's discretion. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

Making and Keeping Appointments

When you make your appointment, be sure to let our receptionist know the nature of your visit (ear pain, rash, complete physical). Also, please let us know at the time you make your appointment if you have a lot of questions/concerns so we can schedule enough time for your visit. If we try to squeeze multiple issues into a single "quick visit", it either results in cutting you off (not fair to you) or making our other patients wait while we finish (not fair to them).

1. The first no show that occurs will result in a phone call reminding you that you missed your appointment and to reschedule.
2. The second no show will result in a letter reminding you that you missed your appointment and to reschedule.
3. The third no show will result in a warning letter of dismissal
4. The fourth no show will result in termination of physician-patient relationship. This will be determined by the doctor.

Prescription Refill Request

When calling in for a prescription refill, please allow 72 business hours for the request to be completed. Please plan ahead so you do not run out of important medications.

Patient Name: _____ Date of Birth:_____

Parent/Guardian Signature: _____ Date: _____