

Adirondack Pediatrics, P.C.

The Laakso Building
84 Broad Street
Glens Falls, NY 12801-4326
518-798-9538

PATIENT'S INSURANCE AUTHORIZATION

Patient's Name _____ Date of Birth _____

Patient's Insurance No. _____

I request that payment of authorized Insurance benefits be made to Doctors James Fuchs, Mary J. Nevins, Roger Levac, Florence Nolan, Lauren Meilhede or Jill Schaefer for any services furnished me by the physician. I authorize any holder of hospital or medical information about my child be released to my child's insurance company and its agents any information needed to determine the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

Patient's Signature (Parent/guardian for minor)

Date

We try to keep our charges to you as reasonable as possible. A major way of accomplishing this is to reduce our billing, which is a very expensive and time consuming process. In order to do this, we ask that you pay the receptionist at the time of each office visit, including co-pays. We realize that there may be times when, because of job or family problems, it may be difficult for you to pay your bill.

In case of divorced or separated parents, **the parent with whom the child(ren) resides is responsible for the bill.** A copy of the receipt can then be used to obtain reimbursement from the financially responsible parent if necessary.

I am aware that payments for self-pays/co-pays and balances are due at the time services are rendered. I will be responsible for any balances due after insurance payment is made.

Patient's Signature (Parent/guardian for minor)

Date

IDENTIFICATION DATA
(Please Print)

DATE _____

Child's Name _____
Last First Middle Nickname

Birth Date _____ ☐ Male ☐ Female

Home Address _____
Street City State Zip

Telephone Number (Home) _____ Cell _____

Father's Name _____ Birth date _____ SSN # _____

Address (if different) _____
Street City State Zip

Father's Employment _____ Work Phone _____

Email _____ Home Phone _____ Cell _____

Mothers's Name _____ Birth date _____ SSN # _____

Address (if different) _____
Street City State Zip

Mother's Employment _____ Work Phone _____

Email _____ Home Phone _____ Cell _____

**In order for us to send claims to your insurance this section
MUST BE COMPLETED and SIGNED on the back**

Pharmacy _____ Phone _____ Address _____

Holder of Insurance _____ D.O.B. _____

Health Insurance _____ Effective Date _____ ID# _____

Group Name/Employer _____ Group # _____

Co-Pay \$ _____

Secondary Insurance _____ ID #/Holder of Insurance _____

Group/Employer _____ Co-Pay \$ _____ D.O.B. _____ effective date _____

Medicaid (if any) # _____ Caseworker: _____ seq. # _____

Referring Physician _____

Emergency Contact _____ Phone _____ Cell _____

Please Sign Back

Initial History Questionnaire

FORM COMPLETED BY _____

DATE COMPLETED _____

Name _____

ID NUMBER _____

BIRTH DATE _____

AGE _____

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History DK = don't know

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No

Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Nasal allergies

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Asthma

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Tuberculosis

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Heart disease (before 55 years old)

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

High cholesterol/takes cholesterol medication

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Anemia

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Bleeding disorder

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Dental decay

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

Cancer (before 55 years old)

☐ Yes ☐ No ☐ DK

Who _____

Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

Biological Family History (Get name from family map) DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Additional family history _____					

Past History DK = don't know

Does your child have, or has your child ever had,	☐ Yes	☐ No	☐ DK	When _____
Chickenpox	☐ Yes	☐ No	☐ DK	Explain _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____
Has had first period ☐ Yes ☐ No	Age of first period _____			
Any other significant problem _____				

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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