

## New Patient Medical Information

Patient's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Parent's Cell Phone: \_\_\_\_\_ Parent's Cell Phone: \_\_\_\_\_

Parents's Business Phone: \_\_\_\_\_ Parent's Business Phone: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

## Family History

Please check only if the patient has an affected parent, sibling or grandparent.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure                       | <input type="checkbox"/> Epilepsy/Seizures                 |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Cancer                            |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Developmental Delay<br>e.g. Down Syndrome | <input type="checkbox"/> Tay-Sachs /<br>metabolic diseases |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Heart Disease before<br>age 50 yrs.       | <input type="checkbox"/> Muscular<br>Dystrophy             |
| <input type="checkbox"/> Migraines          | <input type="checkbox"/> Thyroid Disease                           | <input type="checkbox"/> Tuberculosis                      |

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Past Medical History

Was patient conceived using in vitro fertilization, egg donation, etc.? If so, please explain. \_\_\_\_\_  
\_\_\_\_\_

Were there any complications during pregnancy? If so, please describe.  
\_\_\_\_\_

Was the patient born vaginally or by Caesarian Section? \_\_\_\_\_

Were there any complications at or shortly after delivery? \_\_\_\_\_  
\_\_\_\_\_

What was the patient's birth weight? \_\_\_\_\_ Birth length? \_\_\_\_\_

Has the patient ever been seriously ill or hospitalized? \_\_\_\_\_  
\_\_\_\_\_

Does the patient have any chronic or recurrent illnesses? \_\_\_\_\_  
\_\_\_\_\_

Does the patient currently take any medications? \_\_\_\_\_  
\_\_\_\_\_

Does the patient have allergies to any medications? \_\_\_\_\_

Has the patient ever undergone surgery? \_\_\_\_\_  
\_\_\_\_\_

Please use this space to add any information which you think we should be informed of:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Notice of Privacy Acknowledgement

Gables Pediatrics, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health insurance, I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices, I also understand that this practice has the right to change its Notice of Privacy Practices, I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

\_\_\_\_\_  
**Patient Name or Legal Guardian (print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

*Office Use Only*

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

**Date:** \_\_\_\_\_

**Attempt:** \_\_\_\_\_

**Staff Name:** \_\_\_\_\_

PRIMARY LANGUAGE \_\_\_\_\_

DATE \_\_\_\_\_

### PATIENTS' INFORMATION

PATIENT'S NAME \_\_\_\_\_  
LAST FIRST MIDDLE

BIRTHDATE \_\_\_\_\_ SEX \_\_\_\_\_ ALLERGIES \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_  
CITY STATE ZIP

TO SEE DOCTOR \_\_\_\_\_ REFERRED BY \_\_\_\_\_

BROTHERS \_\_\_\_\_ SISTERS \_\_\_\_\_

### PARENT'S INFORMATION

MARITAL STATUS \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_ D.O.B \_\_\_\_\_ S.S # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
CITY, STATE ZIP \_\_\_\_\_ CELL # \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ BUSINESS PHONE ( ) \_\_\_\_\_

E-Mail \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_ D.O.B \_\_\_\_\_ S.S # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
CITY, STATE ZIP \_\_\_\_\_ CELL # \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ BUSINESS PHONE ( ) \_\_\_\_\_

E-Mail \_\_\_\_\_

NEAREST RELATIVE(S) \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

**HIPPA Notice Received & Reviewed**

### INSURANCE INFORMATION

(For Office Use Only)

Please check here if any of the above information has changed in the last 12 months.

## AUTHORIZATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

May we leave the following types of messages at your home, work, cell or emergency contact numbers?

(1) Appointment changes \_\_\_\_\_ Yes \_\_\_\_\_ No

(2) Test Results \_\_\_\_\_ Yes \_\_\_\_\_ No

(3) Prescription Info \_\_\_\_\_ Yes \_\_\_\_\_ No

(4) Billing Answers \_\_\_\_\_ Yes \_\_\_\_\_ No

(5) Telephone Nurse Advise \_\_\_\_\_ Yes \_\_\_\_\_ No

Yes	No	I hereby authorize the physician(s) of Gables Pediatrics, to provide medical treatment to the patient on this form.
Yes	No	In the event that my child's legal guardian(s) is/are not able to be present during an office visit, I allow the person who accompanies my child (i.e., family member/friend, nanny, etc.) to make medical decisions on my behalf. (Note: Responding "no" to this statement would require a notarized statement indicating the names of the persons authorized to make such decisions.)
Yes	No	I hereby authorize third parties to pay directly to the physician(s) any insurance benefits due for services rendered on behalf of the named patient.
Yes	No	I authorize the physician(s) to furnish my insurance company and / or third party payers (or their representatives), any medical information necessary to process our insurance claims.
Yes	No	I understand that I am responsible for payment and all charges for medical services rendered to the named patient
Yes	No	As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of " <u>Notice of Privacy Policy</u> ". I have read the Privacy Policy and understand my rights contained in the notice.
Yes	No	By way of my signature, I provide Gables Pediatrics, my authorization and consent to use and disclose my child's protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_