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.

□ Diabetes	□ High Blood Pressure	□ Epilepsy/Seizures
□ Allergies	□ Asthma	□ Cancer
□ Bleeding Disorders	□ Developmental Delay e.g. Down Syndrome	□ Tay-Sachs / metabolic diseases
□ Anemia	□ Heart Disease before age 50 yrs.	□ Muscular Dystrophy
□ Migraines	□ Thyroid Disease	□ 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 _____ ZIP _____ CELL # _____
CITY, STATE

EMPLOYED BY _____ BUSINESS PHONE ( ) _____

E-Mail _____

PARENT'S NAME _____ D.O.B _____ S.S # _____

ADDRESS _____ ZIP _____ CELL # _____
CITY, STATE

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 "Notice of Privacy Policy". 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: _____