Pediatric New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Home Phone: _____ Mobile Phone: _____
Preferred (circle) : Home / Cell Email: _____ Gender: _____

Primary Pediatrician: _____ Phone: _____
Pediatrician Address: _____
Referring Provider: _____ Phone: _____
Referring Address: _____
Preferred Pharmacy: _____ Phone: _____
Preferred Pharmacy Address: _____

Parent 1 Name: _____ DOB: _____
Phone: _____ Email: _____
Occupation: _____ Marital Status: _____ Spouse: _____
Parent 2 Name: _____ DOB: _____
Phone: _____ Email: _____
Occupation: _____ Marital Status: _____ Spouse: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
- □ Decline Response
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race:
- □ Decline Response
- □ American-Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Other
- □ Decline Response

Preferred Language:

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

☐ Received ☐ N/A (only if you received the notice from ColumbiaDoctors previously)

myColumbiaDoctors Patient Portal Sign Up

Access your child's (or your) personal records securely, 24/7, on a computer, smartphone, or tablet. See brochure for details.

Patients 11 and younger: □ Send an invitation to join myColumbiaDoctors to the email address circled above for Parent 1 __/ Parent 2___. □ Opt out

Patients 12 and older: □ Send an invitation to join myColumbiaDoctors to the patient email address above. □ Opt out

Look for an email invite from noreply@followmyhealth.org and click the Registration link.

Insurance Plan information Disclosure and Consent

ColumbiaDoctors will provide you with information regarding the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Portal Sign Up, Insurance Information).

Patient or Legal Guardian Name (Print): _____
Patient or Legal Guardian Signature: _____ Date: _____

***Please refer to our website, columbiadoctors.org, for a list of insurances accepted by your provider.**

Medical and Social History

Reason for today's visit:

Is patient adopted? □ Y □ N *If 'Y', please answer the following to the best of your knowledge.*

Which pregnancy is patient? _____ Birth weight: _____ Born by: □ C-Section □ Vaginal Delivery

Weeks' gestation at birth? _____ If C-section, why? _____

Please describe any health problems the mother or patient experienced during pregnancy or after birth, if any:

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? □ Y □ N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL current medications, including over-the-counter, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Please list any past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Reason	Complications

Has the patient EVER had any of the following?

Anemia/Bleeding tendency	□ Y	□ N	Ear/Nose/Throat	□ Y	□ N
Asthma/Breathing problems	□ Y	□ N	Eczema/Skin disorder	□ Y	□ N
Behavioral problems	□ Y	□ N	Eye Disorder	□ Y	□ N
Blood Transfusion	□ Y	□ N	Growth disorder	□ Y	□ N
Bowel/Stomach problems	□ Y	□ N	Heart disorder/defect	□ Y	□ N
Cancer/Leukemia	□ Y	□ N	Kidney/Bladder problems	□ Y	□ N
Chicken Pox/Shingles	□ Y	□ N	Liver disease	□ Y	□ N
Developmental disorder	□ Y	□ N	Seizure or Epilepsy	□ Y	□ N
Diabetes	□ Y	□ N	Thyroid disorder	□ Y	□ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Additional Pediatric Orthopedic Information:

Please answer ALL QUESTIONS to the best of your ability

OFFICE USE ONLY

Name: _____ Age: ____

MRN# _____

Height: _____ Weight: _____ BP: _____

Temp: _____ If female, age of 1st menses? _____

CHIEF COMPLAINT

Reason for today's visit: _____

Symptoms/complaints & date of onset: _____

_____

_____

Pain severity: scale of 1 (no pain) to 10 (worst pain imaginable). Circle number below:

1 2 3 4 5 6 7 8 9 10

Pain is (Circle): Dull? Sharp? Tingling? Other: _____ Pain occurs? (Circle) At rest? With activity? At night?

What do you use to reduce the pain? (Circle): Medicine? Ice? Heat? Rest? Elevation?

Is problem improving, worsening or stable? _____

Other symptoms associated with the current problem? _____

_____

Is there a family history of this problem? _____

If this is an injury, how did it occur? _____

_____

Have you seen any other doctors (including in an ER) for this? If yes, whom, when, what treatment was given?

_____

_____

_____

FAMILY HISTORY

Patient's Mother's health: _____Father's health: _____

Patient's Sister/Brother's health: _____

Patient's Sister/Brother's health: _____

SOCIAL HISTORY

What is your child's grade in school _____ N/A _____

Do they attend a special needs facility (specify)_____

Languages spoken at home (circle all that apply): English Spanish Other_____

Who lives at home with you? _____

Frequency of Exercise/Organized Sports (circle): Daily Weekly Monthly Gym Class Only Rarely/ Never

Specific type of exercise/ sports: _____

_____

Describe any braces or orthotics your child uses including pattern of use: _____ _____

_____

Does your child receive:

Physical Therapy? No Yes Frequency _____ School based? Y N

Speech Therapy? No Yes Frequency _____ School based? Y N

Occupational Therapy? No Yes Frequency _____ School based? Y N

Is child enrolled in Early Intervention or Birth to 3? Y N

DEVELOPMENTAL DATA

At what age did patient first: Sit:_____ Stand_____ Walk? _____

Special concerns with development? _____

_____

_____

_____

Reviewed by: _____ **,M.D. Date**: _____

PLEASE LIST ALL DOCTORS/PROVIDERS TO WHOM WE SHOULD SEND A REPORT

NAME	SPECIALTY	ADDRESS	PHONE NUMBER

Parent/Guardian signature: _____ Date:_____

Scan Folder: Registration Form

Revised 1/5/16