

Name:

DOB:

### 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 and 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 ..... <input type="checkbox"/> Y <input type="checkbox"/> N  | Ear/Nose/Throat ..... <input type="checkbox"/> Y <input type="checkbox"/> N         |
| Asthma/Breathing problems ..... <input type="checkbox"/> Y <input type="checkbox"/> N | Eczema/Skin disorder ..... <input type="checkbox"/> Y <input type="checkbox"/> N    |
| Behavioral problems..... <input type="checkbox"/> Y <input type="checkbox"/> N        | Eye Disorder ..... <input type="checkbox"/> Y <input type="checkbox"/> N            |
| Blood Transfusion..... <input type="checkbox"/> Y <input type="checkbox"/> N          | Growth disorder..... <input type="checkbox"/> Y <input type="checkbox"/> N          |
| Bowel/Stomach problems ..... <input type="checkbox"/> Y <input type="checkbox"/> N    | Heart disorder/defect ..... <input type="checkbox"/> Y <input type="checkbox"/> N   |
| Cancer/Leukemia ..... <input type="checkbox"/> Y <input type="checkbox"/> N           | Kidney/Bladder problems ..... <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chicken Pox/Shingles ..... <input type="checkbox"/> Y <input type="checkbox"/> N      | Liver disease ..... <input type="checkbox"/> Y <input type="checkbox"/> N           |
| Developmental disorder ..... <input type="checkbox"/> Y <input type="checkbox"/> N    | Seizure or Epilepsy ..... <input type="checkbox"/> Y <input type="checkbox"/> N     |
| Diabetes ..... <input type="checkbox"/> Y <input type="checkbox"/> N                  | Thyroid disorder ..... <input type="checkbox"/> Y <input type="checkbox"/> N        |

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

Name:

DOB:

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Parent:		<input type="checkbox"/> Y <input type="checkbox"/> N	
Parent:		<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling:		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to patient

**Patient Social History**

Does anyone living in your home smoke?  Y  N Do you have pets?  Y  N

Do you smoke?  Y  N  Never If Y, Packs/day \_\_\_\_\_ If N, previously?  Y  N Yrs smoked \_\_\_\_\_ Packs/day \_\_\_\_\_

Do you use other tobacco products?  Y  N Consume alcohol?  Y  N If Y, drinks/week \_\_\_\_\_

For Females: Menses?  Y  N If Y, at what age? \_\_\_\_\_

**OFFICE USE ONLY:**

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