



PARENT OR GUARDIAN INFORMATION

Name: **Mother/Guardian** _____
Address: _____
Home Phone: _____
Employer Name: _____
Employer Address: _____
Work Phone: _____
Social Security #: _____
Date of Birth: _____
Email: _____

Name: **Father/Guardian** _____
Address: _____
Home Phone: _____
Employer Name: _____
Employer Address: _____
Work Phone: _____
Social Security #: _____
Date of Birth: _____
Email: _____

Insurance Information: Who is the policyholder of the Insurance? MOTHER / FATHER (Please Circle One)

Insurance Company: _____
Policy Number: _____
Group Number: _____
Insured: _____

Emergency Information:

Person to Contact: _____
Address: _____
Phone: _____
Relationship: _____

Referral Information: Whom may we thank for this referral?

Name _____ Address _____

Patient Responsibility Statement and Medical Release Information

I/we, the undersigned, understand that we are responsible for any unpaid balance on this account. North Pinellas Children's Medical Center will file the necessary insurance claims, excluding secondary insurance claims, but I/we understand that we are responsible for any balance left unpaid after 120 days of the date of service. Failure to satisfy this obligation may cause the entire balance to be placed with a collection agency or attorney. I/we will be responsible for any charges incurred for collecting this debt; this includes, but is not limited to, collection fees, credit bureau fees, and any legal expense.

I hereby authorize you to release any and all information which you may possess relating to my examination and illnesses. I understand I may revoke this consent in writing at any time.

Signed _____ Date _____

Relationship if other than patient _____

(Please complete Dependant Child information on reverse side.)



DEPENDANT INFORMATION

CHILD #1

First Name _____ MI _____ Last Name _____

Male / Female (please circle)

Date of Birth _____

Social Security # _____

Child's Primary Care Doctor _____

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or
Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino

CHILD #2

First Name _____ MI _____ Last Name _____

Male / Female (please circle)

Date of Birth _____

Social Security # _____

Child's Primary Care Doctor _____

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or
Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino

CHILD #3

First Name _____ MI _____ Last Name _____

Male / Female (please circle)

Date of Birth _____

Social Security # _____

Child's Primary Care Doctor _____

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or
Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino

CHILD #4

First Name _____ MI _____ Last Name _____

Male / Female (please circle)

Date of Birth _____

Social Security # _____

Child's Primary Care Doctor _____

Preferred Language - (circle one) English / Spanish / Other

Race - (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or
Other Pacific Islander / White

Ethnicity - (circle one) Hispanic Latino / Not Hispanic Latino



Date _____

Child's Name _____ DOB _____

Parents' Names _____

Siblings' Names _____

FAMILY HISTORY

Circle all diseases below that have occurred in this child's brothers, sisters, parents, grandparents, aunts, uncles, or first cousins.

Please **specify who** (in relationship to the child) in the space next to the illness and their approximate age at diagnosis.

Asthma	High blood pressure	Anemia
Sinus Allergies	High cholesterol	Bleeding disorder
Eczema	Heart attack / stroke	Anesthesia reactions
Cystic fibrosis	Diabetes	Depression / anxiety
Birth defects	Kidney problems	Substance abuse
Seizures	Digestive problems	Cancer (specify type)
ADHD	Liver problems	Other _____

BIRTH HISTORY - circle italicized options that apply.

Did mother receive prenatal care? Yes No

Was baby born *full term* (37-42 weeks) or *premature* (if preemie, how early? _____)

Was it a *vaginal delivery* or *cesarean section* (if c-section, state reason _____)

Did mom have any problems or complications during this pregnancy? No Yes (circle)

Diabetes, high blood pressure, preeclampsia, preterm labor, other _____

Did mom have any of the following infections during this pregnancy? No Yes (circle)

Yeast, herpes, gonorrhea, chlamydia, syphilis, HIV, urinary tract infection

Did mom test positive for group B strep (GBS) during this or a previous pregnancy? No Yes

If yes, did she receive antibiotics during labor? No Yes Don't know

What was baby's birth weight? _____ Mom's blood type _____

Did baby have any problems in the newborn nursery before hospital discharge? Yes No (circle)

Jaundice, low blood sugar, feeding problems, breathing problems or needed oxygen, Heart murmur, suspicion of infection, sepsis, pneumonia, other _____

Name of birth hospital _____ How long did he / she stay? _____

Did he / she have to go to the NICU or special intensive care unit for newborns? No Yes

Was baby at least 48 hours old when the newborn metabolic screen (PKU) was done? No Yes

Did he / she pass the newborn hearing screen with both ears? No Yes



PAST MEDICAL HISTORY - Please explain any Yes answers

Any hospitalizations?	No	Yes
Any surgeries?	No	Yes
Any serious injuries, concussions, or broken bones?	No	Yes
Taking any medications, vitamins, herbals, or fluoride?	No	Yes
Any allergies to medications?	No	Yes
Any allergies to foods?	No	Yes
Any reactions to any immunizations?	No	Yes
Any chronic cough or recurrent wheezing or pneumonia?	No	Yes
Ever diagnosed with asthma or reactive airway disease?	No	Yes
Any nasal or sinus allergies?	No	Yes
Any eczema or skin problems?	No	Yes
Any vision or hearing impairments?	No	Yes
History of frequent ear infections?	No	Yes
Any heart problems or heart murmur?	No	Yes
Any stomach or digestive problems?	No	Yes
Any kidney or urinary tract problems?	No	Yes
Any seizures, tics, or migraines?	No	Yes
Any developmental delays or learning disabilities?	No	Yes
Any severe behavioral problems or psychiatric illness?	No	Yes

LEAD RISK ASSESSMENT (Check all that apply)

- Home or daycare built before 1970 before 1950 has chipping / peeling paint
 Child eats dirt, clay, or paint chips likes to suck on windowsills or blinds
 Child's friends, playmates, or neighbors with high lead levels
 Parent's job / hobby involves lead exposure Folk remedy with lead (Azarcon)
 None of the above

TB RISK ASSESSMENT (Check if your child has close contact with an adult who . . .)

- Is homeless or living in a shelter
 Is living or working in a prison
 Is living or working in a nursing home
 Has TB, HIV, AIDS, or abuses drugs
 Immigrated from Central or S. America, Haiti, Russia, E. Europe, India, or SE Asia
 Is a healthcare worker (If yes, are they screened regularly? _____)
 None of the above.