NE Pediatrics - NMHC

Date: _____/_____/_____

Patient Name:_____

DOB: _____/_____/_____

Birth History

How old was mom at time of delivery? _____years
In what trimester was prenatal care begun? 1st 2nd 3rd
What was your baby's weight at birth? _____ lbs _____ oz
Was the baby full term? Yes No
Were there any problems with the pregnancy? Yes No
How many days did your baby stay in the hospital? _____ days
Did your baby stay in the NICU? Yes No
Did your baby receive their Hepatitis B Vaccine in the hospital? Yes No
Did your baby have any problems directly after birth? *If yes, please explain. (If no, leave blank.)*

_____
_____

Family History

How many siblings? _____Brothers _____Sisters In good health? ____Yes ___No

Has this child or any blood relative had any of the following? ***Please circle all that apply*

	Who (Paternal or Maternal)?		
ADD/ADHD	_____	Genetic Disorder	_____
Allergies	_____	High Cholesterol	_____
Birth Defects	_____	High Blood Pressure	_____
Asthma	_____	Learning Disabilities	_____
Cancer	_____	Migraines	_____
Heart Disease	_____	Scoliosis	_____
Depression	_____	Seizure Disorder	_____
Developmental Delays	_____	Thyroid Disease	_____
Diabetes	_____	Other	_____

Past Medical History

Has the patient ever been diagnosed with any of the following?

_____Anemia _____Chicken Pox _____Constipation _____Eczema _____GERD/Reflux
_____Headaches _____Hearing Problems _____Heart Murmur _____Prematurity _____Ear Infections
_____Respiratory Problems Other_____

Past Surgical History

Has the patient ever had any of the following surgeries? If so, when?

_____Appendectomy year____ _____Adenoidectomy year ____ _____Hernia Repair year ____
_____Tubes in Ears year____ _____Dental Surgery year ____ _____Tonsillectomy year ____
_____Other Surgery: _____

(For any questions that do not apply to your child's age, skip to the next question.)

Do you have any concerns about your child's bowel habits? Yes No

Do you have any concerns about your child's bladder habits? Yes No

Do you have any concerns about your child's sleep habits? Yes No

Is your child still breast or bottle fed? Yes No Formula Name____

What other types of drinks does your child take? *(Circle all that apply.)*

Water Juice Soda Tea Milk (Skim, 1%, 2%, whole) Other_____

What types of foods does your child eat? *(Circle all that apply.)*

Fruits Vegetables Cereals Meats Dairy

Do you have any concerns about your child's diet? Yes No

With whom does the child primarily reside? *(Circle all that apply.)* Both Parents Mother Father

Grandparents Legal Guardian Step Parent Foster Parents

Other_____

Health and Safety

What is your main source of water? Municipal Well Bottled

Does your child use a car seat? *(Circle the type.)* Front Facing Booster Rear Facing None

If your home was built before 1970, has it been tested for lead? Yes No N/A

Do you have smoke detectors in your home? Yes No N/A

Do you have a pool or spa at your home? Yes No N/A

Does any member of the family smoke in your home or car? Yes No N/A

Does any member of the family smoke outside the home or car? Yes No N/A

Do you have firearms (loaded or unloaded) in your home? Yes No N/A

Does this child have trouble in school? Yes No N/A

Do you have any pets at your home? Yes No N/A

Is there an If so what type? _____

_____

_____

NORTHEAST MISSOURI HEALTH COUNCIL
Partners for a lifetime of health

HIPAA

PATIENT NAME_____**DOB**_____/_____/____
(Please Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for: **treatment, payment, and healthcare operations.** I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time and that I may contact NMHC at any time to receive a current copy.

Patient/Guardian Signature_____**Date**_____/_____/_____

INSURANCE/TX AUTH

PATIENT NAME_____**DOB**_____/_____/____
(Please Print)

ASSIGNMENT OF INSURANCE BENEFITS & TX AUTH:

I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

I, the undersigned, consent to Northeast Missouri Health Council providers and staff to perform medical/dental examinations, testing and treatment as directed by my provider. I understand that I have the right to discuss with my provider the purpose, potential risks, and benefits of any ordered tests or treatment options. I understand that if invasive or interventional tests or procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures. I understand that the consent will remain fully effective until it is revoked in writing.

Patient/Authorized Person's Signature_____**Date**_____/_____/_____

CONSENT TO TREAT/ACCOMPANY MINOR

(For patients under the age of 18 years)

DATE: _____/_____/_____

CHILD'S NAME:_____ DOB _____/_____/_____

This document is my consent as parent/guardian of the above-named child for any treatment or procedure deemed necessary by the professional staff of Northeast Missouri Health Council *(to include NE Family Health, OB/Gyn Specialty Group, NE Pediatrics, NE Dental, Kahoka Dental, Edina Family Health, NE Family Health in Milan, Macon Family Health, and Macon Dental.)*

Additionally, I authorize the following individual(s) to bring the above-named child to these clinics, besides myself: *(please print names)*

_____/_____
(relationship)

_____/_____
(relationship)

_____/_____
(relationship)

Patient/Guardian Signature_____Date_____/_____/_____