NE Pediatrics - NMHC

Date: ______/______/______
Patient Name:____
DOB: ______/______/_____

Nutrition

Evaluation of this child's appetite		____Excellent	____Good	____Fair	____Poor		
Does this child take a vitamin?		____Yes	____No				
Does this child eat	Vegetables	____Yes	____No	Milk Products		____Yes	____No
	Fruit	____Yes	____No	Type of Milk	skim	1%	whole
	Cereal/Bread/Pasta	____Yes	____No	Meat		____Yes	____No

Medications

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Allergies

Medicine____
Food____
Other____

Past Medical History

Has this child had any of the following?

	Yes	No	When		Yes	No	When
Measles	____	____	________	Frequent Sore Throat	____	____	________
Mumps	____	____	________	Trouble Breathing	____	____	________
Rubella	____	____	________	Trouble Seeing	____	____	________
Chicken Pox	____	____	________	Bed Wetting	____	____	________
Scarlet's Fever	____	____	________	Kidney Problems	____	____	________
Convulsions/Seizure	____	____	________	Abdominal Pain	____	____	________
Asthma	____	____	________	Chest Pain	____	____	________
Heart Murmur	____	____	________	Trouble Hearing	____	____	________
Freq Colds/Allergies	____	____	________	Bowel Problems	____	____	________
Freq. Ear Infections	____	____	________	Nausea/Vomiting	____	____	________
				Broken Bones	____	____	________

Surgery	____	____	________	Reason________________________________
Hospitalization	____	____	________	Reason________________________________
Other Serious Problems or Accidents	____	____	________	Reason________________________________

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	____________________

Social History

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With whom does this child primarily reside ? (Circle all that apply.) Both parents Mother Father
Legal Guardian Brother(s) #____ Sister(s) #____ Step Parent
Grandparents
Foster Parents Other____

Does you child have a TV in their bedroom? Yes No
How many hours of TV/computer games does you child do per day? __________ hours

What activities and sports does your child participate in? *(Circle all that apply.)*
Dance Running Bicycle Basketball Football Wrestling Cheerleading
Aerobics Baseball/Softball Swimming Yoga Weights Hiking Volleyball Soccer
Tennis Walking Other____
How many hours per week do they participate in these activities? ____________ hours

How many servings per day do you think your child gets of the following? *(Serv. size ages 5-9 = 1/2 cup, over 10 yrs = 1 c*
Fruits ________ Vegetables ________ Breads/Cereals ________ Proteins/Meats ________ Dairy ________

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
When was the last time your child was seen by a dentist? date _____/_____/_____
Did the dentist have any concerns at that time? Yes No
If yes, what were the concerns? ____

Health and Safety

Does your child use a car seat/seatbelt? *(Circle the type.)* Front Facing Booster Seatbelt 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

For Teens If so what type? ____

Do you drink alcohol?			
Do you smoke or chew tobacco?	Yes	No	If so, how much_______________________
Do you smoke marijuana or take drugs?	Yes	No	If so, how much_______________________
Are you sexually active?	Yes	No	If so, which ones______________________
Do you use birth control?	Yes	No	
What do you plan to do when you graduate from high s	Yes	No	If so, what kind_______________________

For Girls Only:

Have you had your first period?		
Would you like to learn more about periods?	Yes	No
Do you have cramping with your periods?	Yes	No
Are your periods regular?	Yes	No
Are you taking birth control pills?	Yes	No
Have you ever been pregnant?	Yes	No
	Yes	No

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_____/_____/_____

NORTHEAST MISSOURI
HEALTH COUNCIL
Partners for a Lifetime of health

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_______/_______/______