A Bright Future Pediatrics

2100 Hedgcoxe Road Suite 190 Plano, TX 75025 (972) 208-8668 Fax (972) 208-3186

Registration Form **Today's Date:** ________________

1. Patient Name: ______________________ Date of Birth: ____________ Gender: __________
2. Patient Name: ______________________ Date of Birth: ____________ Gender: __________
3. Patient Name: ______________________ Date of Birth: ____________ Gender: __________
4. Patient Name: ______________________ Date of Birth: ____________ Gender: __________
5. Patient Name: ______________________ Date of Birth: ____________ Gender: __________
6. Patient Name: ______________________ Date of Birth: ____________ Gender: __________

Physical Address: ______________________ ______________________
Street City State Zip

Mailing Address: ______________________ ______________________
Street City State Zip

Primary Home Phone: ______________________ Primary Cell Phone: ______________________

Primary E-mail: ____

(Please write clearly - This E-mail address will be used for the Patient Portal Login)

How would you like us to contact you for:

Medical Issues – Primary Phone Number to Call (Choose One Only)

- o Home Phone: ______________________
- o Cell Phone: ______________________

Appointment Reminders to Confirm Your Scheduled Appointment (Choose One Only)

- o Home Phone: ______________________
- o Cell Phone: ______________________
- o Text to Cell: ______________________
- o Primary E-mail: ______________________

Recall to Remind to Schedule Appointment (Choose One Only)

- o Home Phone: ______________________
- o Cell Phone: ______________________
- o Text to Cell: ______________________
- o Primary E-mail: ______________________

General Notices (Choose One Only)

- o Home Phone: ______________________
- o Cell Phone: ______________________
- o Text to Cell: ______________________
- o Primary E-mail: ______________________

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Ethnicity: (Circle one) Hispanic Latino or Spanish Origin Non-Hispanic Other Primary Language: ___________

Race: (Circle) White African American Pacific Islander American Indian or Alaska Native Asian Other

Pharmacy: Name: ________________________________ Address: ____
Phone: ________________________________

GIVE BOTH PARENTS/LEGAL GUARDIANS INFORMATION

Parent Name: ________________________________

Relationship to child: __________________________

Social Security Number: ________________________

Date of Birth: ________________________________

Employer: ___________________________________

Occupation: __________________________________

Cell Phone: __________________________________

Work Phone: _________________________________

Parent Name: ____

Relationship to child: ________________________________

Social Security Number: _______________________________

Date of Birth: ____

Employer: ____

Occupation: ____

Cell Phone: ____

Work Phone: ____

Alternative E-mail Address: ____

Is there custody information that we need to be aware of? YES NO

Can we send you electronic updates from our practice to your primary patient portal email? YES NO

Do you consent to receiving text messages from A Bright Future Pediatrics? YES NO
(standard text message rates may apply)

Text to this phone number: ______________________________

Insurance Information

Responsible party (Card Holder's Name): _________________________________ Date of Birth: ______________________

Social Security Number: ____ Gender: ____________________________

Employer: ____ Occupation: __________________________

Insurance Company: ____ Effective Date: ______________________

Card Holder's Policy/Identification #: ___________________________________ Group #: ____________________________

Claims Address: ____ ____
(on back of card) Street City State Zip

Provider/Customer Service Phone Number: ____

Family Name or Initials: ______________________________________

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Child #1

Patient's Name: ______________________ Date of Birth: ____________

Relationship to Child: ____________

Child lives with: MOTHER FATHER BOTH PARENTS OTHER: ____________

☐ Check here if the insurance ID is the same as Card Holder's and complete below if it is different:

Policy/Identification Number: ____________ Group Number: ____________

Child #2

Patient's Name: ______________________ Date of Birth: ____________

Relationship to Child: ____________

Child lives with: MOTHER FATHER BOTH PARENTS OTHER: ____________

☐ Check here if the insurance ID is the same as Card Holder's and complete below if it is different:

Policy/Identification Number: ____________ Group Number: ____________

Child #3

Patient's Name: ______________________ Date of Birth: ____________

Relationship to Child: ____________

Child lives with: MOTHER FATHER BOTH PARENTS OTHER: ____________

☐ Check here if the insurance ID is the same as Card Holder's and complete below if it is different:

Policy/Identification Number: ____________ Group Number: ____________

Child #4

Patient's Name: ______________________ Date of Birth: ____________

Relationship to Child: ____________

Child lives with: MOTHER FATHER BOTH PARENTS OTHER: ____________

☐ Check here if the insurance ID is the same as Card Holder's and complete below if it is different:

Policy/Identification Number: ____________ Group Number: ____________

Child #5

Patient's Name: ______________________ Date of Birth: ____________

Relationship to Child: ____________

Child lives with: MOTHER FATHER BOTH PARENTS OTHER: ____________

☐ Check here if the insurance ID is the same as Card Holder's and complete below if it is different:

Policy/Identification Number: ____________ Group Number: ____________

Please let us know if you need additional sheets for more children.

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Registration Acknowledgement

I verify that this information is correct and up-to-date. I agree to update A Bright Future Pediatrics of any changes to the information above. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If, in using the information I have provided today or on previous occasions, A Bright Future Pediatrics is unable to collect from my child's insurance company, I accept full responsibility for the payment of my child/children's bills. I also understand that if my insurance recoups payments I am responsible for all charges, even if more than a year has passed since the date of service.

I also understand that if there is a legal contract in a divorce situation where one parent is responsible for medical bill payments, that this is not a contract between you and our practice. In this instance, whoever is present for the visit with the patient is responsible for all copay, coinsurance, out of pocket expenses, or deductibles incurred on the date of service and remaining balance in the system.

Responsible Party (print name): ____ Date: ______________________________

Signature: ____

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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

(Other than Parent or Guardian)

I ___________________________________, give permission for my child/children to be medically evaluated and treated at A Bright Future Pediatrics in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation.

Patient Name: ____ Date of Birth: _____________________

Patient Name: ____ Date of Birth: _____________________

Patient Name: ____ Date of Birth: _____________________

I/We, the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint the following adults to act on my/our behalf in authorizing medical, surgical care and hospitalization for the above named minor(s) during the period of my/our absence from: ________________________ to ______________________.
Date Date

Name of appointed Adult	Relationship to Patient	Phone Number
Name of appointed Adult	Relationship to Patient	Phone Number

This consent applies to but not limited to:

Complete physician check-up (including blood and urine samples), hearing, vision, VEP, immunizations, first aid and emergency care, prescription(s) and treatment for illness, referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

This document shall be presented to a physician or appropriate hospital representative at such time as medical, surgical care or hospitalization may be required.

In case of emergency, I can be reached at: (Contact Number): ____

FINANCIAL RESPONSIBILITY

I understand that payment is expected at the time of service and will ensure that the above mentioned appointed caretaker has the required insurance information and the means to pay the co-pay/co-insurance due at the time of service. I accept full responsibility for the charges accrued in the healthcare of my child(ren) if the physician, dentist, hospital, or other ancillary healthcare provider is unable to collect from my insurance company.

Signature of Parent/Legal Guardian	Printed Name of Parent/Legal Guardian	Date
Signature of Witness	Printed Name of Witness	Date

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Office Policies

Welcome to A Bright Future Pediatrics! We are so happy that you have chosen to make us your child's medical home. We strive to create an atmosphere that is friendly and warm for our patients and look forward to taking care of your children for years to come. The practice is growing, and we would like to help the patients and parents make a smooth transition in regards to changes that will be taking place. We hope the following information is helpful in informing every one of our office policies and procedures and provides a more pleasant environment.

Appointment Policy

Sick and Well Waiting

We have provided sick and well waiting areas to help prevent the well children from being exposed to any illness the other children that are arriving for a sick visit may have. If you come to the office with more than one child and one of your children is sick, then you must report to the sick waiting room. Newborns and children here for well exams, rechecks, or follow-up exams from a previous illness who are no longer symptomatic should report to the well waiting room. Please help the spread of germs and keep your child in the sick waiting area if they are being seen for an acute sickness.

Sick Appointments: Acute sick appointments are scheduled as same day appointments only. There may be a wait time as we will be working you in between the regular scheduled appointments. Chronic sick appointments and consultations generally require more time than a standard acute sick appointment and will need to be scheduled two weeks or more in advance.

Well Child Appointments: We recommend scheduling well visits 6-8 weeks in advance. This assures that your child will have their well visit and immunizations on time. We recommend vaccines per AAP/CDC guidelines and follow all AAP guidelines for well child visits.

Cancellations: If you should need to cancel a pre-scheduled appointment, please notify our office 24 business hours in advance so that we may accommodate families who are on a waiting list for an earlier appointment. Failure to cancel your appointment within 24 business hours will result in a $25.00 charge. This charge must be paid prior to scheduling your next appointment.

No-Shows: There will be a no-show fee for every no-show appointment:
Appointments not cancelled 24 hours in advance – Fee $25.00
No show for standard length appointments – Fee $50.00
No show for behavioral appointments (ADD/ADHD, Anxiety, etc.) – Fee $75.00

Failure to notify our office with a cancellation at least one hour prior to your appointment time will result in the above no-show fees. Our office policy states that 3 or more no shows are grounds for dismissal from the practice. This is not to be uncaring; it is an effort to continue prompt care throughout the day for our ill children. These charges will not be billed to your insurance company; you will be responsible for payment.

Late for Scheduled Appointments: If you are going to be more than 10 minutes late, please call our office so we can reschedule your appointment for a more convenient time. If your child is sick, you may wait in the office and be worked in between patients. Please note, there may be an extended wait time if you are late for your appointment.

Immunization Policy

Our physicians believe that all children should be fully immunized unless there are medical contradictions. Therefore, we are no longer accepting new patients/families unless they are willing to fully comply with the recommended timetable for vaccine administration per the American Academy of Pediatrics. We are committed to providing quality care and have a duty to protect our entire patient population. We have a duty to protect our newborns and other children with immune deficiencies.

Family Name or Initials: ______________________________

After Hours Calls

We have a physician on-call 7 days a week for emergencies only. We no longer have a nurse triage after hours. If you have routine questions, please call during our normal office hours. All after hours calls will be answered within a timely manner. A charge of $25.00 may occur for all non-emergency physician phone calls outside of normal office hours. If you have a question regarding medication dosage, please call your 24-hour pharmacy or your insurance nurse line.

Release of Medical Records

Our office has 15 business days to release your child's medical records. There will be a $35.00 charge for copying your child's chart for the first 30 pages, $0.25 for each additional page. Medical records may be transferred to another physician, pending an authorization release is obtained. This will be free of charge for the first transfer. Any additional transfers will result in the listed fees. We can also release your child's medical records on a disc for a flat fee of $30.00 with no page limitations.

Shot Records/School Forms

Immunization records can be accessed and printed at any time from the patient portal found on our website. Immunization records will be released within 2-3 business days after request. Please allow 3-5 business days for your school, camp, and sports physical forms. There is a $10.00 charge for letters or forms needing more than a signature. Detailed forms and letters will be charged according to the amount of time required to complete. Please note that forms only requiring a signature can be signed during your office visits at no charge, so please bring them to your appointment.

Medication Refills

Please allow our office 72 hours for prescription refills. Medication refills will only be done during our normal business hours. The on-call physician will not prescribe non-urgent refills after hours or on weekends. Patients must be seen prior to filling any new prescriptions that our office did not originally prescribe. Controlled medications (such as those for ADHD) cannot be e-scribed and will require a visit every 3 months. Other prescriptions require a visit at least every 6-12 months, depending on the medication.

Please request all prescription refills via the Patient Portal.

Document Rush

Provided we have written consent, we are happy to complete, sign, and return any document to you, your child(ren)'s school, or another medical office. Our physicians take first priority on seeing patients and each physician has specific times for document and chart review. Because of this, unless otherwise stated in this policy, all documents will have a 5-7 business day return. If you require a document to be returned before that window, a $25.00 rush fee will be applied. Please be aware that all physicians may not be onsite each day of the week.

Returned Checks

There will be a $30 fee for any returned checks.

Threats

We apologize for having to express this up front in our office policy, but in the world today, we must maintain a zero-tolerance policy for verbal or physical threats made against our physicians or staff. If a threat is made either verbally or in written form, the physician-patient relationship has been compromised, and the patient (and any family members, if applicable) will be discharged from the practice.

Family Name or Initials: ________________________________

Legal action

If legal actions occur in which a physician or any employee of A Bright Future Pediatrics is requested or subpoenaed to provide testimony (such as a custody case), you will be responsible to pay A Bright Future Pediatrics directly for providing the following services: (a) the time spent preparing for court, (b) the time spent for transportation to/from court, and (c) the time spent appearing in court. Charges for legal services will be billed at $400.00 per hour. If this legal action requires the physician to step away from patient care for an entire day, the fee will be $10,000 for each day that they are unable to see patients. This fee is NOT reimbursable by a Third-Party Payer and is therefore the full legal responsibility of the patient and/or the patient's parent or legal guardian.

Custody/Divorce Agreements

Divorce decrees are a contract between two parents and not the physician and the parent. We cannot and will not withhold patient information from one parent at the request of the other parent without receiving a copy of the divorce decree verifying full custody. Unless a divorce decree is submitted to the patient's chart, we will provide care for the child regardless of which parent is at the appointment. Payment is due at time of service regardless of which parent holds the financial responsibility for medical services.

Well Child Checkup V.S. Sick Exam – What's the difference?

Our physicians want to devote your entire appointment time on the purpose for your visit. If you have previous medical history or concerns that you wish to discuss, you should schedule an appointment specifically for that issue, so we may focus your well child exam on growth and wellness. A well child exam and a sick/diagnostic exam are billed differently, so if they are combined into one appointment, you may receive two bills. To help explain, please read this excerpt from Cigna's website: "If your provider finds a health problem during a wellness exam, you may have to pay. Why? Once a problem is found, your exam is no longer considered preventative-it becomes diagnostic, or non-routine. When diagnostic care is needed, your out-of-pocket costs depend on your coverage and tests for services needed."

Patient Portal Features

Login to the website with a unique and secure login ID and update your contact information. Look up your child's most recent visit including the date, weight, and height at last visit. Review and print your child's vaccination and allergy records including a record of vaccines administered. Request appointments for well visits and prescription refills. Request referrals or school/camp forms (which can be emailed to the patient after reviewed by a physician). Contact the Nursing department with any non-urgent questions. *For the usage of this portal and online statements, please make sure that our office has your current email address and that all of your information has been updated within the last 6 months.*

Please go to our website at www.ABFPediatrics.com, and on the top right-hand corner you will see the link to the patient portal.
Any messages sent to the doctor, nursing, billing, or receptionist department will be addressed in the order in which they are received within a 24-hour regular business period. Please do not contact via Patient Portal with any urgent questions.
Please call us at 972-208-8668

By signing below, you acknowledge and fully understand the Office Policies.

________________________	________________________	__________
Signature of Parent/Legal Guardian	Printed Name of Parent/Legal Guardian	Date

Financial Obligation

All payment is due at the time of service.

This office is contracted with most major insurance plans. All patients are expected to provide our office with current insurance information and to understand their benefits. For the convenience of our patients, our providers participate in a variety of managed care plans. Our office also acts as an advocate for our patients with their managed care plans. This may include completing pre-certifications, eligibility verification, or other similar paperwork on behalf of the patient. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

Patient Financial Responsibilities

- The patient (or legal guardian, if a minor) is ultimately responsible for the payment for the patient's treatment and care.
- Patients (or legal guardian, if a minor) are responsible for the payment of co-pays, deductibles, coinsurance, and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, checks, MasterCard and Visa.
- If patient (or legal guardian, if a minor) pays by check and it is returned due to insufficient funds, there will be a $30 returned check fee.

Primary Care Physicians: If you are required by your insurance company to select a primary care physician, this must be done prior to your child's appointment.

Our mission as a practice is to provide for the health and well-being of our patients. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Financial Obligation Policy.

HIPAA (Health Insurance Portability and Accountability Act)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have rights to privacy regarding my protocol health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payments from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications. I understand that as part of my healthcare, A Bright Future Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have received, read, and understand, or declined to read, your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Health Insurance Portability & Accountability Act.

______________________________ Signature of Parent/Legal Guardian

______________________________ Printed Name of Parent/Legal Guardian

____________ Date

Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications

The Patient Portal is provided by A Bright Future Pediatrics as a courtesy for the exclusive use of its patients and authorized parents, legal guardians, and/or other caregivers. By logging in, you attest that you are a member of one of the aforementioned groups and will use any confidential medical information that is disclosed to you only for its intended purpose. Any other use is strictly forbidden. If you believe that the security of your account has been compromised, please notify us immediately so we can reset your credentials.

To better serve our patients, this office has established an e-mail address for some forms of communication. **For routine matters that do not require an immediate response**, please feel free to contact us at any of the following e-mails:

- office1@abfpediatrics.com : You can use this e-mail for the following inquiries: medical records, educational materials, and patient forms.
- billing@abfpediatrics.com: You can use this e-mail for the following inquiries: billing, payments, or insurance questions.

The turnaround time for routine patient communication is typically within 2 business days; however, inquiries requiring extensive involvement of the physician may cause a delay in message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending an e-mail, please put the subject of the message in the subject line so we may process it more efficiently. Some forms of communication (e.g., HIV and mental health) are not appropriate for e-mails. Also, be sure to put the name and birthdate of the patient as well as a return telephone number in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using auto reply feature.

Communication relating to diagnosis and treatment will be filed in your medical records.
This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and that your messages may be monitored. In addition, you should be aware that although an e-mail may be addressed to one person, our entire staff will have access to this information. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications.

Welcome to A Bright Future Pediatrics!

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CONSENT ACKNOWLEDGEMENT

1. Patient Name ____ Date of Birth _________________
2. Patient Name ____ Date of Birth _________________
3. Patient Name ____ Date of Birth _________________
4. Patient Name ____ Date of Birth _________________
5. Patient Name ____ Date of Birth _________________

1. **HIPPA (Health Insurance Portability and Accountability Act):** I hereby acknowledge that I have been presented with a copy of A Bright Future Pediatrics (ABFP) Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand I am not required to agree to (ABFP) requested restrictions, but if parents agree, then parent is bound to abide by such restrictions.
   Parent/Guardian_________
2. **A Bright Future Pediatrics Financial Obligation Policy:** I have read, understand, and will comply with the Financial Obligation Policy. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or in previous occasions, A Bright Future Pediatrics is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.
   Parent/Guardian _________
3. **Appointment Policy/Office Policies:** I hereby acknowledge that I have been presented with a copy of A Bright Future Pediatrics Office/Appointment Policies handout and understand my responsibilities. I have read and understand them.
   Parent/Guardian _________
4. **Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications:** I hereby acknowledge that I have been presented with a copy of A Bright Future Pediatrics Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications policies and understand my responsibilities.
   Parent/Guardian _________

The office policies and protocols will be updated periodically as the practice grows and changes will be made accordingly. These updates will be available on our website as well as in our office.

I acknowledge that I have read this document in its entirety and fully understand it and will comply with all of A Bright Future Pediatrics policies and protocols, or I have declined to read. I also acknowledge I have been given copies of all the policies mentioned above, if requested, and I was given the opportunity to ask any questions.

Today's Date: ____

Print Parent/Guardian Name: __________________________________ Signature: ___________________________________

Print Witness Name: ____ Signature: ___________________________________

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NEW PATIENT QUESTIONNAIRE

Patient's Name:________________________________ DOB:_________________Today's Date:__________________

Mother's Name: _______________________Age: ___ Father's Name: ________________________________ Age:___

PREGNANCY AND BIRTH

Mother's age at child's birth: _____________________________
What number pregnancy was this child? __________________
Did mother have any illness during pregnancy? Y N
If yes, list illness: _________________________________

Did mother take any medications other than vitamins and iron?
If yes, list medications: ____________________________

Was the baby on time? Y N
If no, how early was your baby? ______________________

Were there any complications with the baby during delivery?
Y N
____

Was the delivery vaginal or by C-section? (Circle one)
Y N

Did the baby go home at the same time as mom?
Y N

Did the baby have any trouble while in the hospital? (Jaundice, Infections, other?) Y N
If yes, list issues: _________________________________
____

Did the baby go to the NICU? Y N

If yes, please give a brief synopsis of the course:

If so, how long were they admitted? ___________________

If on ventilator, how long? ____________________________

If on oxygen, how long? ______________________________

Other info (infections, surgeries, interventions) while in NICU:
____
____
____
____
____

Birth Weight _____________ Birth Length_____________

Are your child's vaccinations up to date? Y N

If not, why?
____
____
____

FEEDING AND NUTRITION

Is your child's appetite usually good? Y N

Was there severe colic or any unusual feeding problems during the first 3 months? Y N

Do any foods disagree with him/her? Y N
If so, what?___________________________________

For the first 6 months, is he/she (was he/she) breast-fed or bottle-fed? ______________________________

If still on formula, which one? ___________________
____

Does he/she take vitamins? Y N

DEVELOPMENT / BEHAVIOR

At what age did child sit alone?____________________

At what age did child walk alone? _________________

Did child say any words by the time he/she was 1 ½ years old?
Y N

How does child compare to others of the same age?
____

Does child have any trouble sleeping? Y N

What grade is the child in? _______________________

Family Name or Initials: ________________________________

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DEVELOPMENT / BEHAVIOR (CONTINUED)

Has child had any trouble in school? Y N

Does child get along with other children? Y N

Does child have any of the following? (Circle all that apply)

Thumb sucking	Nail biting
Bed wetting	Bad temper
Problems with toilet training	Hyperactivity
Problems with discipline	Nightmares
Speech problems	Other

List: ____________________________________

PAST MEDICAL HISTORY

Where has you child gone for check-ups until now?

____

Date of last check-up? ____________________________

Date of last dental check-up? ________________________

Are any medications taken regularly? Y N

Please list names, dosages, and frequency taken:

____
____
____
____
____

If female, have periods started? Y N
When? ____________________________________
List any problems or concerns regarding periods: __________
____
____

SAFETY / ENVIRONMENT

Do you live in a: (Please circle)

Private home	Apartment
Mobile home	Other: ________________

Day care?____________Sitter? ________________

Child lives with…? (Circle one)

Mother	Father	Both Parents

Other relatives: ______________________________

SAFETY / ENVIRONMENT (CONTINUED)

Do you know the hottest temperature of the water in your pipes? Y N

Is there a working smoke alarm on each floor in the house? Y N

Does your child always use a car seat/seat belt when riding in the car? Y N

Are there any smokers in the household? Y N

Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) Y N

Are there any guns in the house? Y N

Are there any pets in the house? Y N

Has your child had any of the following medical problems? (Please circle all that apply)

Serious injuries or accidents	Surgeries
Hospitalizations	Chicken pox disease
Frequent ear infections	Hearing loss
Heart problem or murmur	Anemia or bleeding problem
Diabetes / blood sugar problems	Frequent abdominal pain
Blood transfusion	Kidney problem
Bladder or kidney infection	Eczema
Bedwetting (after 6 years of age)	Learning disorder
Use of alcohol or drugs	Frequent headaches
Constipation requiring Dr Visits	Surgery

Allergies-seasonal, animals, indoor, foods

Allergic reactions-medications, vaccinations

Convulsions or other neurological problems

Thyroid or other endocrine problems

Other significant problem: ________________________

Family Name or Initials: ______________________________

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FAMILY HISTORY

(Mark if present in any of your child's siblings, aunts/uncles, first cousins, or grandparents)

Spina Bifida	Vision / eye problems
Bone disorder	Cerebral Palsy
Cleft lip / palate	ADD / learning disorder
Hearing loss	Convulsions
Heart disease / defect	Infertility
Neurofibromatosis	Limb defects
Mental retardation	Down Syndrome
Neurological disorder	Cystic fibrosis
Mental illness	Short stature (<5ft)
Tuberculosis	Diabetes
Hay fever / allergies	Drug / alcohol problems
Sickle Cell Anemia	Bleeding disorder
Muscle disorder	Kidney disease
Skin disease	Genital abnormality
High blood pressure	Asthma
Urinary tract abnormality	AIDS (HIV)
High cholesterol / triglycerides	Chromosome abnormality
Brain anomalies (includes Hydrocephaly)	Anemia (includes Thalassernia)

Patient's mother was exposed to DES

Other birth defect/malformations/problems?
Please list: ______________________________

____

____

____

Siblings: List health problems, gender, date of birth, date of death (if applicable): ______________________________

____

____

____

Family Name or Initials: ______________________________