



Pediatric Health Record

Dear Patients: Welcome to our office! While the following form may take a few minutes to complete, please fill in as much as possible, even the parts that do not seem important. The information that you provide will help us to take better care of your child today and in the future.

NAME: _____ DATE OF BIRTH _____
 SEX: Male / Female AGE: _____ RACE : (for insurance purposes) _____
 PARENT/GUARDIAN NAME: _____

GENERAL HEALTH AND DEVELOPMENT:

What is the chief reason that your child is being seen today?

Are there other problems that you are concerned about or questions you would like answered? (please list) _____

PREGNANCY AND BIRTH HISTORY

(Circle: YES or NO)

Did you have any problems while pregnant with this child? (If yes, please explain)	Yes	No
Did you take any medications other than prenatal vitamins during this pregnancy? (If yes, please list)	Yes	No
Did you have an unusually long or difficult labor or delivery?	Yes	No
Was this child born in a hospital?	Yes	No
Was this child born head first	Yes	No
Was this child born by cesarean section?	Yes	No
Your child's birth weight was _____ lbs. _____ oz.		
Was your child normal at birth?	Yes	No
Did this child go home from the hospital at the same time as you did?	Yes	No
Did your child need any special treatment while in the hospital such as an incubator, oxygen, blood transfusion, IV, etc.? (If yes, please explain)	Yes	No
FEEDING HISTORY (FOR INFANTS ONE YEAR OR LESS)		
Was (is) this child breast fed? If yes, how long?	Yes	No
Type of formula or milk? _____ How many ounces per day? _____		
Do you give additional vitamins?	Yes	No

Has your child ever had a reaction to a medicine or a shot? Yes No
 If yes, please explain _____

Please list any medicines that your child takes everyday including over the counter medicines _____

IMMUNIZATION HISTORY

(Circle: YES or NO)

Are your child's immunization up to date?	Yes	No
If your child is over 1, has he/she had the chickenpox vaccine?	Yes	No
If your child is over 6, has he/she had the second MMR (measles-mumps-rubella) vaccine?	Yes	No
Has your child had the hepatitis B vaccine (the HBV not the HIB vaccine)?	Yes	No

HAS YOUR CHILD EVER. . .

(Circle: YES or NO)

Been Hospitalized? (If yes, please list)	Yes	No
Had an operation? (If, yes, please list)	Yes	No
Do you feel you have had more than the usual problems in managing your child? (Please explain if yes)	Yes	No
Does your child get along well with other children?	Yes	No
Do you think that your child is too clumsy?	Yes	No
Do you think your child is able to do the things other children his/her age can do?	Yes	No

SCHOOL HISTORY: In the past year has your child:

(Circle: YES or NO)

Missed more than 7 days of school because of illness?	Yes	No
Has your child had trouble keeping up with his/her classmates in his/her schoolwork?	Yes	No
Has your child ever had to repeat a school grade?	Yes	No
Has your child ever had complaints about his/her behavior in school?	Yes	No
Has your child ever had medicine to "calm him/her down?"	Yes	No

FOR GIRLS OVER AGE 10:

(Circle: YES or NO)

Have your menstrual periods started?	At what age did they start?	Yes	No
Are your periods regular?		Yes	No
Do you have pains or cramps?		Yes	No

MEDICAL HISTORY

(Circle: YES or NO)

Has your child ever had?	Yes	No	Has your child ever had?	Yes	No
Whooping cough?	Yes	No	Seizures or convulsions?	Yes	No
Chicken pox?	Yes	No	Asthma or wheezing?	Yes	No
Meningitis?	Yes	No	Bladder or urine infection?	Yes	No
Repeated ear infections?	Yes	No	Heart murmur?	Yes	No
Pneumonia?	Yes	No	Hearing problems?	Yes	No
Anemia?	Yes	No	Loss of consciousness?	Yes	No
Jaundice?	Yes	No	Speech problems?	Yes	No
Chronic constipation?	Yes	No	Rheumatic fever?	Yes	No
Broken bones?	Yes	No	Skin problems/chronic rashes?	Yes	No
Persistent diarrhea?	Yes	No	Tuberculosis?	Yes	No

FAMILY

	Age	Health if Living	Age at Death	Cause of Death
Father				
Mother				
Mother's mother				
Mother's father				
Father's mother				
Father's father				
Please list patient's siblings:				
1.				
2.				
3.				

FAMILY HEALTH

(Circle: YES or NO)

(Circle: YES or NO)

Has any blood relative ever had:			Has any blood relative ever had:		
Heart trouble before age 50	Yes	No	Cancer	Yes	No
High Blood pressure	Yes	No	Tuberculosis	Yes	No
Stroke before age 60	Yes	No	Diabetes	Yes	No
Lung disease before age 40	Yes	No	Anemia	Yes	No
Blindness before age 50	Yes	No	Sickle Cell Disease	Yes	No
Color blindness	Yes	No	Migraine	Yes	No
Nervous breakdown	Yes	No	Asthma	Yes	No
Kidney trouble	Yes	No	Allergies/Hay Fever	Yes	No
Easy bleeding	Yes	No	Obesity	Yes	No
Congenital malformations	Yes	No	Retardation	Yes	No
Convulsions or seizures	Yes	No	Deafness	Yes	No
Cystic Fibrosis	Yes	No	Thyroid trouble	Yes	No

<p>Please list any other diseases which run on either side of your child's family:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any significant family or marital problems? Yes No (If yes, please explain) _____</p> <p>_____</p> <p>_____</p>	<p><u>Office Use Only</u></p> <p>PLEASE REVIEW</p> <p>_____</p> <p>DR'S SIGNATURE</p> <p>_____</p> <p>DATE</p>
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Thank you for taking the time to complete this questionnaire.

Parent/Guardian Signature

Date

Medical Record # _____

CPAK – 06/13/07

Patient Information (Confidential)

MRN # _____

Name _____ Home Phone _____
(First) (Middle) (Last) (Goes By/Nickname)
 Address _____ Apt/Lot # _____
 City _____ State _____ Zip _____ Cell Phone _____
 Date of Birth _____ SS # _____ Sex: Male Female
 Employer _____ Work Phone _____ Ext. _____

Check Appropriate Box: Single Married Divorced Widowed

If Student, Name of School/College _____ Full Time Part Time

Primary Care Physician _____ Referring Physician _____

Emergency Contact(s): Name _____ Relationship _____ Phone _____
 Name _____ Relationship _____ Phone _____

Person Financially Responsible (Guarantor)

Person Responsible for Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Cell Phone _____
 Date of Birth _____ SS # _____ Sex: Male Female
 Employer _____ Work Phone _____ Power of Attorney _____

Insurance Information

Name of Insurance Company _____ Copy of ID # _____
 Card Provided OR Group # _____
 Name of Insured (Subscriber) _____ Pt Relationship to Insured: 1 Self 2 Spouse 3 Child
 Insured Address _____ City/State/Zip _____
 Date of Birth _____ SS # _____ Home Phone _____
 Name of Employer _____ Work Phone _____ Ext. _____
 Employer Address _____ City/State/Zip _____

*****DO YOU HAVE ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING: *****

Name of Insurance Company _____ Copy of ID # _____
 Card Provided OR Group # _____
 Name of Insured (Subscriber) _____ Pt Relationship to Insured: 1 Self 2 Spouse 3 Child
 Insured Address _____ City/State/Zip _____
 Date of Birth _____ SS # _____ Home Phone _____
 Name of Employer _____ Work Phone _____ Ext. _____
 Employer Address _____ City/State/Zip _____

Authorization for the release of medical information and assignment of benefits

I authorize the release of my medical records from Cornerstone Healthcare, P.A. in order to process any claims. I authorize you to release copies of my medical records including current and previous records from other medical facilities to other offices which are a part of Cornerstone Healthcare, P.A. I hereby authorize payment directly to this medical association for the medical care and/or surgical benefits that is entitled to under my insurance plans. I understand that as the patient (or the patient's parent/guardian) I am responsible for any unpaid balance on this account. I also understand that if any charges are not covered by insurance, workers' compensation or other third party payers, I am responsible for full payment. I understand that fees for visits, examinations or treatments are payable at the time of service unless covered by insurance or arrangements have been made in advance. Fees for special medical reports are payable in advance. Charges for accidental injury are payable at the time of service, regardless of any pending litigation or settlement.

Signature: _____ Date: _____
 Patient/Parent/Person Financially Responsible

CORNERSTONE HEALTH CARE, P.A.

HIPAA CONSENT FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO OUR PATIENTS:

Patient information will be maintained by Cornerstone as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in compliance with federal and state regulation. You may obtain a copy of the Notice of Privacy Practices by contacting the Office Manager.

Cornerstone reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work related injury to your employer. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

We reserve the right to:

- Call you to remind you of your next appointment and/or leave information on your answering machine.
- Call you with lab and/or test results and leave information on your answering machine.
- At what number(s) would you like to be contacted? _____
If we cannot contact you at the above number(s), numbers from the information sheet will be used.
- Contact you for potential research that might benefit your well-being.

If there is anyone that you would like us to share your health information with, please list the names and their relationship to the patient below:

I have read and understand my rights.

Signature of patient or legal guardian

Date

Signature of CHC witness

Print the name of the patient

DOB/Acct #

CORNERSTONE
Pediatric Associates
OF KERNERSVILLE

861 OLD WINSTON ROAD, SUITE 103, KERNERSVILLE, NC 27284
PHONE (336) 802-2300, FAX (336) 802-2301

CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name _____
Patient's Address _____
Patient's Birth Date _____
Patient's Social Security Number _____

RELEASE/OBTAIN FROM:

Phone Number: _____ Fax: _____

I, do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. **PLEASE NOTE:** This authorization **does not** include information about alcohol, drug, and psychiatric information; and any information relating to HIV Testing, AIDS, and AIDS-Related Syndromes. I agree that a copy of this release or fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

- SEND ALL MY RECORDS
- SENSITIVE INFORMATION HAS BEEN DELETED AT THE PATIENT'S REQUEST.
- SEND RECORDS FROM (DATE) _____ (TO) _____
- SEND ALL MY PERTINENT MEDICAL RECORDS

RELEASE/SEND RECORDS TO:

Phone Number: _____ Fax: _____

Patient/Parent's Signature

Date

Witness