Carolina Kids Pediatric Associates, PLLC

Patient Information: *Please list all children on this form to avoid having to complete a separate form for each child.*

Patient #1: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

Patient #2: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

Patient #3: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

If more than 3 children, ask for a second form and list names here:

Children's primarily live with: (Name and relationship)

First Parent Contact: Relationship to patient

Name: Last First MI

DOB Cell Phone Home Phone Maiden

Address Apt/Unit #

City State Zip Email (printed clearly)

Second Parent Contact: Relationship to patient

Name: Last First MI

DOB Cell Phone Home Phone Maiden

Address Apt/Unit #

City State Zip Email (printed clearly)

Individuals Authorized to bring patient and oversee care:

1. Full Name Relationship Phone#

2. Full Name Relationship Phone#

Primary Insurance Info: *Our office has contractual timely filing limits with insurance providers. Therefore, you may be responsible for claim balances if valid ins info is not provided within 85 days of service.* **To prevent filing errors, provide all active insurance information. By law Medicaid is payer of last resort.**

Primary Insurance: Patient policy ID# Group#

Policy Holder: Name DOB Relationship to Patient

Secondary Insurance: Patient policy ID# Group#

Policy Holder: Name DOB Relationship to Patient

Primary Provider: (circle one) Willey Emmet Hernandez Micaela Jennifer Chambers

First Language Race Ethnicity (circle) Hispanic Non-Hispanic

How should we contact you for: **Well Check recalls** ☐ Call ☐ Text ☐ Email

Appointment Reminders ☐ Call ☐ Text ☐ Email

Billing Statements ☐ Mail ☐ Patient Portal

Test Results: ☐ Call ☐ Text ☐ Email

All emails and texts are generated by our EMR.

I authorize Carolina Kids Pediatric Associates to file insurance claims for services provided and for payments of services to be made to same. I understand that I am responsible for any remaining balance or non-covered charges. You CANNOT delegate another person to be the responsible party. Copays and balance payments are expected at time of service. If a court agreement states that another parent is financially responsible for these medical costs, it is the accompanying parent's responsibility to pay at the time of the visit and collect reimbursement from the responsible parent.

Responsible Party Name: Print Name:

Signature: **Date:**

Carolina Kids Patient History Questionnaire

Patient's Full Name: _____ Date of Birth:_____

Birth History:

Prenatal health problems: _____ Place of birth: _____

Preterm birth: Y N If yes, how premature? _____

Problems identified in newborn period: _____

Past Medical History:

Has your child had any of the following? *(IF CHILD IS A NEWBORN, PLEASE SKIP THIS SECTION)*

Current medications	Y	N	_____
Medication allergies	Y	N	_____
Serious injuries or accidents	Y	N	_____
Surgeries	Y	N	_____
Hospitalizations	Y	N	_____
Chickenpox	Y	N	_____
Frequent ear/sinus infections	Y	N	_____
Frequent pharyngitis/tonsillitis	Y	N	_____
Other serious infections	Y	N	_____
Nasal allergies/food allergy	Y	N	_____
Environmental allergies	Y	N	_____
Asthma or chest infections	Y	N	_____
Heart problems	Y	N	_____
Abdominal problems	Y	N	_____
Urinary infections	Y	N	_____
Bedwetting (after 5 years)	Y	N	_____
Eye conditions/glasses	Y	N	_____
Ear/hearing problems	Y	N	_____
Skin problems	Y	N	_____
Anemia/bleeding problem	Y	N	_____
Blood transfusions	Y	N	_____
Frequent headaches	Y	N	_____
Seizures/neurologic problems	Y	N	_____

Patient's Full Name: _____ Date of Birth:_____

ADHD/developmental delay	Y	N	_____
Mental health concerns	Y	N	_____
Orthopedic problems	Y	N	_____
Diabetes	Y	N	_____
Thyroid problems	Y	N	_____
Girls: menstrual problems	Y	N	N/A _____
Adolescents: drug/alcohol use	Y	N	N/A _____
Emotional problems	Y	N	_____
Other problems	Y	N	_____

Family Medical History:

(Circle all that apply and include name of affected family member beside condition)

Nasal allergies : _____
Asthma/lung disease: _____
Heart disease: _____
High blood pressure: _____
High cholesterol: _____
Diabetes: _____
Cancer: _____
Anemia : _____
Hearing problem: _____
Immune problem: _____
Drug abuse: _____
Tuberculosis: _____

Bleeding problem: _____
Seizures/neurologic: _____
Developmental delay: _____
ADHD: _____
Liver problem: _____
Other GI problem: _____
Kidney disease : _____
Bedwetting (after 10):_____
Vision problem: _____
Alcohol problem: _____
Mental illness: _____
Other: _____

Social History:

Who lives at home? _____

Do any family members live outside the home? _____

Are there any custody arrangements we should be aware of? _____

Are there any animals in the house? _____

Are there any stressors in your home we should be aware of? _____

Patient's Full Name: _____ Date of Birth:_____

Carolina Kids Risk Assessment Questionnaire

Lead Risk Assessment:

1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent or ongoing remodeling? YES NO

2. Has your family/child ever lived outside the U.S. or recently arrived from a foreign country? YES NO

   Where? _____

Tuberculosis Risk-Assessment:

1. Was your child born in a country other than the United States? YES NO

   If yes, where was he/she born? _____

2. Has your child traveled to another country? YES NO

   If yes, where did he/she travel and for how long? _____

3. Has your child been exposed to anyone with tuberculosis? YES NO

4. Does this child have close contact with anyone with a positive tuberculosis skin test? YES NO

5. Does this child spend time with anyone who has been in jail or a shelter, uses illegal drugs, or has HIV/AIDS? YES NO

7. Does any person live or work in this child's home who was born in a country other than the United States or has had significant foreign travel to high risk areas? YES NO

   If yes, what country or countries and for what time period? _____

Other Risk Assessment:

1. Does anyone in your home or in a home your child visits frequently use cigarettes or tobacco products? YES NO

2. Does your home have access to city water or a community well which has fluorinated water? YES NO

3. Do you have firearms in your home? YES NO

4. If yes, are firearms locked in a secure location? YES NO

5. In the past month, was there any day when you or anyone in your family went hungry because you did not have enough money for food? YES NO