PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (check)	Date of Birth	Marital Status (check)	Primary Care Physician
☐ M ☐ F		☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Other: _____	

Preferred Language (check)	Race (check)	Ethnicity (check)
☐ English ☐ Spanish _____	☐ Asian ☐ Black ☐ White ☐ Other: _____	☐ Hispanic ☐ Not Hispanic ☐ Unknown

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: ☐ Patient

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Responsible Party?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City / State	Zipcode

Emergency Contact

Check if same as: ☐ Responsible Party

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Emergency Contact?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact

Check if same as: ☐ Responsible Party ☐ Emergency Contact

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Guardian?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information

Check if: ☐ **Self Pay**

Check if same as: ☐ Responsible Party			Check if same as: ☐ Responsible Party		
Subscriber / Member Name		Date of Birth	Subscriber / Member Name		Date of Birth
What is Patient's Relationship to Subscriber?		Gender (check) ☐ M ☐ F	What is Patient's Relationship to Subscriber?		Gender (check) ☐ M ☐ F
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City / State	Zipcode	Insurance Mailing Address	City / State	Zipcode
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient/Legal Guardian Signature Date

Patient/Legal Guardian Print

Initial History Questionnaire

Form Completed By:	Name:		
Initial Date Completed:	ID Number:		
Date(s) Updated:	Birth Date:	Age:	Sex: M F

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Don't know Explain: _____

Does your child have any special health care needs? ☐ Yes ☐ No ☐ Don't know Explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Don't know Explain: _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Don't know Explain: _____

SOCIAL HISTORY

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? ☐ Yes ☐ No

If no, what is the child's current living situation?

☐ Single-parent custody ☐ Joint custody ☐ Adoptive family

☐ Other family members: _____ ☐ Foster care

How often does the child have visitation with parent(s) not living in the home?

_____

Instructions for health care professionals on how to use this form can be found in the *User Guide and Instructions for Toolkit Implementation* at https://toolkits.solutions.aap.org/bright-futures.

BIRTH HISTORY

Birth weight: _____

☐ Full-term ☐ Preterm _____ weeks ☐ Post-term _____ weeks

Delivery: ☐ Vaginal ☐ Cesarean ☐ Reason: _____

Any complications during birth or after birth? ☐ No ☐ Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

☐ No ☐ Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins?	☐ Yes	☐ No	☐ Unknown
Smoke or use e-cigarettes?	☐ Yes	☐ No	☐ Unknown
Drink alcohol?	☐ Yes	☐ No	☐ Unknown
Use marijuana?	☐ Yes	☐ No	☐ Unknown
Use illicit drugs?	☐ Yes	☐ No	☐ Unknown
Take other medications?	☐ Yes	☐ No	☐ Unknown

If yes, please list: _____

_____

Blood type:

Mother: _____ ☐ Unknown

Baby: _____ ☐ Unknown

Mother's lab results:

Hepatitis B	☐ Pos	☐ Neg	☐ Unknown
HIV	☐ Pos	☐ Neg	☐ Unknown
Group B streptococcus (GBS)	☐ Pos	☐ Neg	☐ Unknown

After birth, did the baby get:

Vitamin K shot?	☐ Yes	☐ No	☐ Unknown
Erythromycin eye ointment?	☐ Yes	☐ No	☐ Unknown
Hepatitis B shot?	☐ Yes	☐ No	☐ Unknown

How was the baby fed? ☐ Bottle formula ☐ Bottle breast milk

☐ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? ☐ Yes

☐ No Explain: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

HE0564

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

Name: _____

PAST MEDICAL HISTORY (*continued*)

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

_____

_____

_____

_____

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

_____

_____

_____

_____

Name: _____

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

Condition	DK	No	Yes	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed-wetting (after age 10 years)					
Cancer (before age 55 years)					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack (myocardial infarction)					
Heart disease (before age 55 years)					
High blood pressure					
High cholesterol					
HIV or AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death (before age 50 years)					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other medical problems (Please list.)

_____

_____

_____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

Lakewood Ranch Medical Group
A Division of Manatee Physician Alliance

NOTICE of PRIVACY PRACTICES

A copy of ***Manatee Physician Alliance, LLC*** HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

DISCLOSURE of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

I authorize ***Manatee Physician Alliance, LLC*** to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below.

Name: _____ **Relationship** _____

Name: _____ **Relationship**_____

I authorize ***Manatee Physician Alliance, LLC*** to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. ☐ Yes ☐ No

Emergency Contact: _____ **Phone number**_____ **Relationship:** _____

Email Address: _____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENT of BENEFITS

Manatee Physician Alliance, LLC strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 50% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. ***Manatee Physician Alliance, LLC*** will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to ***Manatee Physician Alliance, LLC*** of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize ***Manatee Physician Alliance, LLC*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize ***Manatee Physician Alliance, LLC*** to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ***Manatee Physician Alliance, LLC***. Any photographs or other images taken will become part of my medical record. ***Manatee Physician Alliance, LLC*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Manatee Physician Alliance, LLC*** will provide me with information and forms prior to such procedures. I grant ***Manatee Physician Alliance, LLC*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***Manatee Physician Alliance, LLC*** to search and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***Manatee Physician Alliance, LLC***.

_____ _____

Patient's Name (Please Print) Signature Date

_____ _____

Patient Representative (If patient is unable to sign) Signature Date