

Children's Community Practices

An Affiliate of Nationwide Children's Hospital

Patient Information Form:

Please Print and fully complete

Patient Information:

First Name _____ Middle Initial _____ Last Name _____
Address _____ City _____ State _____ ZIP _____
DOB _____ Sex: Male Female Phone# _____

Parent or Legal Guardian Information:

First Name _____ Last Name _____ DOB _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-Mail _____ SSN _____ Relationship to Patient _____
Employer _____
Child lives with Mother Father Grandparent Foster parent Legal Guardian Other

Parent or Legal Guardian Information:

First Name _____ Last Name _____ DOB _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-Mail _____ SSN _____ Relationship to Patient _____
Employer _____

Primary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk

Insurance Name _____ Address _____
Policy Holder _____ DOB _____ Employer _____
ID# _____ Group# _____ SS# (If needed for billing) _____

Secondary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk

Insurance Name _____ Address _____
Policy Holder _____ DOB _____ Employer _____
ID# _____ Group# _____ SS# (If needed for billing) _____

Please list all children in your family who come to this practice:

_____ DOB _____ _____ DOB _____ _____ DOB _____
_____ DOB _____ _____ DOB _____ _____ DOB _____

Preferred E-Mail for the patient portal:

Preferred Pharmacy: _____ Address _____ Phone _____

Emergency Contact: Name _____ Relationship _____ Phone _____

How were you referred to this practice? Existing patient Physician Name of patient/physician _____
 Newspaper Telephone Internet Website Insurance company Other _____

I authorize the providers of the practice to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to the practice. If my insurance company rejects or allows only part of the claim for services, I shall be responsible for payment of the balance due and will pay the balance within thirty (30) days.

Printed name of patient or parent/guardian

Signature

Date

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Patient Name _____ Birth Date _____

Past Medical History

Has our child ever been treated or diagnosed with: (explain)

	<u>Yes</u>	<u>No</u>
Asthma/wheezing/pneumonia	<input type="checkbox"/>	<input type="checkbox"/> _____
Allergies- food/pets/seasonal	<input type="checkbox"/>	<input type="checkbox"/> _____
Anemia/blood disorder	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____
Ear infections/strep throat	<input type="checkbox"/>	<input type="checkbox"/> _____
Genetic disorder	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart disease/defects	<input type="checkbox"/>	<input type="checkbox"/> _____
Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/> _____
Neurological (headaches/seizures)	<input type="checkbox"/>	<input type="checkbox"/> _____
Psychological (ADHD, autism, anxiety)	<input type="checkbox"/>	<input type="checkbox"/> _____
Urinary tract infections/disorders	<input type="checkbox"/>	<input type="checkbox"/> _____
Other chronic conditions	<input type="checkbox"/>	<input type="checkbox"/> _____

Has your child ever been hospitalized overnight? Yes No Please explain and give dates _____

Please list any specialist(s) your child is seeing _____

Medications

Allergies to medications and reactions _____

Current medications and dose _____

Vitamins, herbal supplements, over the counter medications _____

Surgical History

Type of surgery and date of surgery _____

Social History

Who lives in the household with your child? Parent (Mom) Parent (Dad) Siblings # _____ Other _____

Parent(s) Married Single Divorced Remarried Name of Step-parent _____

Custody (Please bring in custody papers if other than shared)

Smokers Yes No Pets Yes No What Kind? _____ Age of home _____

Does your child stay home with you? Yes No Does your child attend daycare/preschool/babysitter? Yes No

Developmental

At what age did your child: roll over _____ crawl _____ walk _____ speak 2 words _____

Present grade in school _____

Patients Race: American Indian or Alaska Native Asian White Hispanic Black or African American

Native Hawaiian/Other Pacific Islander Other Decline to report

Patients Language: English Spanish Indian Russian Other _____

Patients Ethnicity: Hispanic or Latin Not Hispanic or Latin Decline to report