*** PARENT/CHILD INFORMATION SHEET ***

When registering, please present proof of insurance. Copay is expected at the time of service, unless special arrangements are made. Payment may be made by cash, check, Visa, MasterCard, and Discover.

PATIENT INFORMATION: DOB: _____ Sex: F or M

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State ___ Zip Code _____

Phone # _____

INSURANCE INFORMATION:

Name of Insurance: _____ Policy # _____

Subscriber of Insurance: _____ Relation to Patient _____

PARENT INFORMATION:

Parent #1 Name _____ DOB _____ Gender_____

Address/Phone # if different from above _____

Employer _____ Cell # _____

Parent #2 Name _____ DOB _____Gender_____

Address/Phone # if different from above _____

Employer _____ Cell # _____

Maiden Name of mother (required by NYS Registry) _____

EMERGENCY CONTACT: _____ **PHONE #** _____

(Person not living with you)

Address: _____

OTHER CHILDREN IN THE FAMILY

(Use back of form if more room is needed)

LAST NAME	FIRST	SEX	DOB	ADDRESS IF DIFFERENT

I herby authorize my insurance benefits to be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also give my consent for the treatment and health care operations required. I have read and/or received the CHCA Notice of Privacy Policies, which applies to all protected health information defined by federal regulations.

PARENT OR LEGAL GUARDIAN SIGNATURE _____ DATE _____/ _____/ _____

Patient's Name: _____

Birth History

Was the baby born at term? ❑ Yes ❑ No ❑ Early? ❑ Late?

If early, how many weeks gestation? _____

Was the delivery ❑ Vaginal? ❑ Cesarean?

If cesarean, why? _____

Birth Weight: _____

Did mother have any illness or problem with her pregnancy? ❑ Yes ❑ No Explain: _____

During pregnancy, did mother? Smoke: ❑ Yes ❑ No Drink alcohol: ❑ Yes ❑ No

Use drugs or medications? ❑ Yes ❑ No What? _____ When? _____

Home Environment

Mother's occupation: _____

Father's occupation: _____

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

Name	Relationship to child	Birthdate	Health Problems

Are parents ❑ single ❑ married ❑ separated ❑ divorced?

If mother and father are not living together or if child does not live with parents,

what is the child's custody status? _____

_____

If one or both parents are not living in the home, how often does he/she see the

parent/parents not in the home? _____

_____

Have there been any significant changes in health of child's immediate family or has

any immediate family member passed away within the past year? _____

_____

Any out of home child care? _____

Does your child always wear a seatbelt? ❑ Yes ❑ No Explain: _____

Does your child wear a bike helmet? ❑ Yes ❑ No Explain: _____

Are there smoke alarms in the home? ❑ Yes ❑ No Explain: _____

Are there guns in the home? ❑ Yes ❑ No Explain: _____

If yes, are they locked? ❑ Yes ❑ No Explain: _____

Is your child exposed to smoke in the home? ❑ Yes ❑ No Explain: _____

Are there pets in the home? ❑ Yes ❑ No Explain: _____

FAMILY HEALTH HISTORY

Patient's Name_____

Have any immediate family members had:	CHILD'S MOTHER	CHILD'S FATHER	CHILD'S SISTER(S)	CHILD'S BROTHER(S)	CHILD'S MATERNAL GRANDMOTHER	CHILD'S MATERNAL GRANDFATHER	CHILD'S PATERNAL GRANDMOTHER	CHILD'S PATERNAL GRANDFATHER
Immune Problems, HIV, AIDS								
Alcoholism								
Addiction—Drugs								
Anemia								
Arthritis (childhood) (JRA)								
Asthma								
Birth Defects								
Bleeding Disorder								
Cancer or Malignancies								
Crohns or ulcerative colitis								
Developmental delay								
Diabetes								
Epilepsy or Convulsions								
(seizures)								
Heart Disease								
(before 50 years old)								
High Blood Pressure								
(before 50 years old)								
Kidney Disease								
Liver Disease								
Mental Illness								
Mental Retardation								
Thyroid Disease								

To better serve our patients we will be able to fax scripts to your pharmacy. To help us with this task please list your primary, secondary and mail order pharmacy used. Thank you

List all dependents (names and DOB)

_____

_____

Primary Pharmacy

Name_____

Address_____

_____

City, St, Zip _____

Phone_____

Is this primary used for all your children? ____

If no which ones? _____

_____

_____

Secondary pharmacy

Name _____

Address_____

_____

City, St, Zip _____

Phone_____

is this pharmacy used for all your children? ____

If no which ones? _____

_____

Mail order

Name_____

Address_____

City, St, Zip_____

Phone_____

Is this pharmacy used for all your children? ___

If no which ones? _____

_____