*** NEW PATIENT INFORMATION SHEET ***

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

PATIENT INFORMATION: DOB: _____ Sex: F or M

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State ___ Zip Code _____

Phone # _____ Email address _____

INSURANCE INFORMATION:

Name of Insurance: _____ Policy # _____

Subscriber of Insurance: _____ Relation to Patient _____

PARENT INFORMATION:

Parent #1 Name _____ DOB _____ Gender_____

Address (if different from above) _____ Billing Address? Yes ☐ No☐

Employer _____ Cell # _____

Parent #2 Name _____ DOB _____Gender_____

Address (if different from above) _____ Billing Address? Yes ☐ No☐

Employer _____ Cell # _____

Maiden Name of mother (required by NYS Registry) _____

DEMOGRAPHIC INFORMATION:

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Other_____

☐ Declined to specify

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Declined to specify ☐ Other_____

EMERGENCY CONTACT: _____ **PHONE #** _____

(Person not living with you)

Address: _____

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 _____/ _____/ _____

For office use only: Packet entered in EMR ☐ Initials _____

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

Parent #1 occupation: _____

Parent #2 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 parents are not living together or if child does not live with parent, 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?

_____

Has there been any significant changes in health of child's immediate family? _____

Any out of home child care? _____

Does your child always ride in a car seat/wear a seatbelt? ☐ Yes ☐ No Explain: _____

Does your child always wear a bike helmet (if age applicable)? ☐ 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: _____

Patient's Name: _____

Illness/Injuries

Do you consider your child to be in good health? ☐Yes ☐No Explain:_____

Does your child have a serious illness or medical condition? ☐Yes ☐No Explain:_____

Does your child have, or has he/she ever had:

Any chronic or recurrent skin problem (acne, eczema, etc.) ☐Yes ☐No Explain:_____

Use of alcohol or drugs ☐Yes ☐No Explain:_____

Nasal Allergies ☐Yes ☐No Explain:_____

Anemia or bleeding problem ☐Yes ☐No Explain:_____

Asthma, bronchitis, bronchiolitis, or pneumonia ☐Yes ☐No Explain:_____

Bed-wetting (after 5 years old) ☐Yes ☐No Explain:_____

Bladder or Kidney infection ☐Yes ☐No Explain:_____

Blood transfusion ☐Yes ☐No Explain:_____

Chickenpox ☐Yes ☐No Explain:_____

Constipation requiring doctor visits ☐Yes ☐No Explain:_____

Convulsions or other neurologic problem ☐Yes ☐No Explain:_____

Diabetes ☐Yes ☐No Explain:_____

Frequent ear infections ☐Yes ☐No Explain:_____

Problems with ears or hearing ☐Yes ☐No Explain:_____

Problems with eyes or vision ☐Yes ☐No Explain:_____

Frequent abdominal pain ☐Yes ☐No Explain:_____

Frequent headaches ☐Yes ☐No Explain:_____

Any heart problem or heart murmur ☐Yes ☐No Explain:_____

Thyroid or endocrine problem ☐Yes ☐No Explain:_____

Any other significant problem ☐Yes ☐No Explain:_____

Has your child had any serious injuries or accidents? ☐Yes ☐No Explain:_____

Is your child allergic to any medications or drugs? ☐Yes ☐No Explain:_____

Current Medications and Doses

1._____

2._____

3._____

4._____

Surgery/Hospitalization

Has your child had any surgery? ☐Yes ☐No Explain:_____

Has your child ever been hospitalized? ☐Yes ☐No Explain:_____

(For Girls) OB-GYN

Has she started her menstrual periods? ☐Yes ☐No Explain:_____

Are there problems with her periods? ☐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 Grandmothe	Child's Paternal Grandfather
Immune problems, HIV, AIDS								
Alcoholism								
Addiction- Drugs								
Anemia								
Birth Defects								
Bleeding Disorder								
Clotting Disorder								
Cancer or Malignancies								
Crohns or ulcerative colitis								
Developmental Delay								
Diabetes								
Epilepsy or Convulsions (seizures)								
Heart Disease (before 50 years old)								
High Blood Pressure								
Hip Dysplasia								
Kidney Disease								
Liver Disease								
Mental Illness								
Intellectual Disability (Mental Retardation)								
Thyroid Disease								

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

Primary Pharmacy

Name _____ Is this the primary used for all of your children? _____

Address _____ If no, which ones? _____

_____ _____

City, State, Zip _____

Phone Number _____

Secondary Pharmacy

Name _____ Is this the primary used for all of your children? _____

Address _____ If no, which ones? _____

_____ _____

City, State, Zip _____

Phone Number _____

Patient Portal Sign up

Patients under the age of 18 require an "authorized representative" which is a parent or guardian. Only one parent can be the authorized representative for a child. Once a patient turns 18 the authorized representative is automatically deactivated and the patient can activate their own portal. If there are multiple children in a family, each patient will have their own account. After all information below is entered into the system, we will mail you an activation letter with instructions and an activation code that you will need to sign in for the first time.

Patient Name_____ Patient Date of Birth _____

Authorized Representative Name _____ Date of Birth_____

Relationship to Patient_____

Authorized Representative Phone Number _____

Authorized Representative Email address _____

Mailing Address: _____

_____

TB Questionnaire

Patient Name_____ DOB:_____

Has a family member or contact had tuberculosis disease?

_____NO _____ YES, EXPLAIN_____

Has a family member had a positive tuberculin skin test result?

_____NO _____ YES, EXPLAIN_____

Was your child born in a high risk country (countries other than US, Canada, Australia, New Zealand, or Western European countries?

_____NO _____ YES, EXPLAIN_____

Has your child traveled (had contact with resident populations) to a high risk country for more than one week?

_____NO _____ YES, EXPLAIN_____

OFFICE POLICY / CONSENT FORM

Patient Name_____ Date of Birth _____

- I have read and understand the Office Policy and Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

x_____ _____
Parent/Guardian Signature Date

HealthEconnections

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Child Health Care Associates to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for Child Health Care Associates to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for Child Health Care Associates to access my electronic health information through HealtheConnections for any purpose, even in a medical emergency.

My questions about this form have been answered and I have been provided a copy of this form if requested.

Sign x_____ _____
(Patient or Patient's Legal Representative) Date

Print Name x_____

Office Use Only: Entered in EMR ☐ Initials_____