*** PARENT/BABY 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, AMEX, 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) _____

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 _____

Patients 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: _____

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 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 patient, we will be able to fax scripts directly 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 _____ 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 _____

Mail Order

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

Address _____ If no, which ones? _____

_____ _____

City, State, Zip _____

Phone Number _____

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_____

IMMUNIZATION NATIONAL RESOURCE WEB SITE DIRECTORY

New York State Department of Health Home Page	http://www.health.state.ny.us
CDC Home Page	http://www.cdc.gov
CDC National Immunization Program	http://www.cdc.gov/nip
American Medical Association	http://www.ama-assn.org
American Academy of Family Physicians	http://www.aafp.org
American Academy of Pediatrics	http://www.aap.org
US Department of Health Services	http://healthfinder.gov
Immunization Action Coalition	http://www.immunize.org
Allied Vaccine Group	http://www.vaccines.org
CDC Travel Website	http://www.cdc.gov/travel
Institute for Vaccine Safety	http://www.vaccinesafety.edu
Immunization Education and Action Committee	http://www.hmhb.org

Child Healthcare Associates
Routine Visit Schedule
Revised 4/17/18

3-5 DAYS OLD: WEIGHT/JAUNDICE CHECK

2 WEEK VISIT: ROUTINE NEWBORN CHECKUP, POSTNATAL SCREEN

2 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS, POSTNATAL SCREEN

4 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS, POSTNATAL SCREEN

6 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS

9 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, VISION CHECK

12 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, HEMOGLOBIN/LEAD LEVEL, IMMUNIZATIONS

15 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS

18 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS, HEMOGLOBIN LEVEL IF NECESSARY

2 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN TB, HEMOGLOBEN/LEAD LEVEL, VISION CHECK

3-4 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, HEARING SCREEN, LEAD SCREEN AS NEEDED

5 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, IMMUNIZATIONS, VISION CHECK, LEAD SCREEN AS NEEDED

6-10 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, MAKE UP IMMUNIZATIONS IF NECESSARY, LEAD SCREEN AS NEEDED

11 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, IMMUNIZATIONS, LIPID PANEL

12-18 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, CARDIAC SCREEN, MAKE UP IMMUNIZATIONS AS NECESSARY, ADOLESCENT SCREENS

19-21 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, CARDIAC SCREEN, MAKE UP IMMUNIZATIONS AS NECESSARY, ADOLESCENT SCREENS, TRANSFER TO ADULT PHYSICIAN