SUMTER PEDIATRICS, P.A.
PATIENT INFORMATION
www.sumterpediatrics.com

Full Name: _____ DOB: _____/_____/_____ SEX: (M) (F)
(Last) (First) (Middle)
Street Address: _____ City: _____ State: _____ Zip Code_____

Contact # :( ) _____ Social Security#:_____-_____-_____ Race: _____ Language: _____

Has this child ever been seen by Sumter Pediatrics,P.A?_____ If So When?_____
Do you have other children that are patients of SumterPediatrics,P.A.? _____

FAMILY

Person Responsible for Patient (Parent or Legal Guardian):_____Email: _____

Father's Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip Code_____

Social Security #: _____ Cell Phone #: _____

Place of Employment: _____ Work Telephone#: _____

Mother's Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip Code_____

Social Security #: _____ Cell Phone #: _____

Place of Employment: _____ Work Telephone #: _____

Emergency Contact: _____ **Telephone #:**_____

INSURANCE

Primary Insurance: _____Eff. Date_____ Primary Policy Number:_____

Policy Holder Name: _____ Telephone: _____

Date of Birth: _____ SSN: _____

Secondary Insurance: _____Eff. Date_____ Secondary Policy Number: _____

Secondary Policy Holder Name: _____ Telephone: _____

Date of Birth: _____ SSN: _____

PHARMACY: _____ADDRESS:_____

PHONE #:_____

PARENT/LEGAL GUARDIAN PERMISSION FOR MEDICAL CARE

I, _____, give _____
(Parent/Guardian) (Relatives, Friends or Babysitter) * Please list all who may apply
_____ permission to get medical care for my child, _____, at Sumter Pediatrics, P.A. This includes any immunizations and/or other medical procedures that may be necessary.

CONSENT

By signing this form, you are granting consent to Sumter Pediatrics, P.A. to use and disclose the protected health information for the purposes of treatment, payment and health care operations for this child. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full and I understand, that my signature on this form states that I have received a copy of the Privacy Policy of Sumter Pediatrics, P.A. for my child.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: Contacting Sumter Pediatrics, P.A. Business Office at 803-775-3813 or visiting www.sumterpediatrics.com.

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO SUMTER PEDIATRICS, P.A.

I hereby authorize the physician designated to release information acquired in the course of my examination and treatment. I hereby assign payment directly to the designated physician for any medical/surgical procedures. I agree that this authorization shall be valid until rescinded in writing.

_____ _____
(Parent/Guardian) (Witness)

_____ _____
(Date) (Date)

Age	Health		Family History
Mother			Miscarriages Month Cause
Father			Heart Attacks/Strokes
Sibling			Allergy
Sibling			Diabetes
Sibling			Mothers Blood Type Rh Baby's Blood Type

PATIENT'S BIRTH/DEVELOPMENT/FEEDING

Term: Full Early Late Delivery: Normal C-Section Birth Weight: _____

Obstetrician:_____Previous Doctor:_____

Gestational Age	Delivery	Weight	Length	HC
Complications			Apgar Store	
Sat up	Fed Self	Grasps	Words	
Breast	Formula		Vitamins/Iron/Floride	

Mother's use of (Please check one): _____Alcohol _____Tobacco _____Drugs _____None

PATIENT'S HISTORY

1. Has the patient had any of the following?
   Heart Disease Pertussis Mumps
   Seizures Measles Chicken Pox
   Diabetes Rubella
   Operation, if so what_____
   Allergic Reactions, if so When_____

2. Has the patient had any of the following?
   Persistent/Productive Cough
   Weight Loss/Gain (other than normal)
   Other_____

3. List all the doctors the patient currently sees.
   a. _____
   b. _____
   c. _____
   d. _____

4. List all the medications this is patient is currently taking.
   a. _____
   b. _____
   c. _____
   d. _____

5. Do you have any concerns regarding this patient's growth and/or development? If so what?
   _____
   _____
   _____

Date _____

Patient's Name _____Date of Birth _____

MEDICAL INFORMATION

Do you consider your child to be in good health?		□No □Yes Explain_____
Besides birth, has your child ever been hospitalized?		□No □Yes Explain_____
Has your child ever had:	A blood transfusion	□No □Yes Explain_____
	Convulsions or seizures	□No □Yes Explain_____
	Heart problems/murmur	□No □Yes Explain_____
	Surgeries	□No □Yes Explain_____
	Serious illnesses	□No □ Yes Explain_____
Does your child have any:	Food Allergies	□No □Yes Explain_____
	Drug Allergies	□No □ Yes Explain_____
Are you concerned about your child's development:		□No □Yes Explain_____
	Physical	□No □ Yes Explain_____
	Mental	□No □ Yes Explain_____
	Social/emotional	□No □Yes Explain _____
Are you concerned about your child's attention span?		□No □Yes Explain_____
Females Only: Has your daughter started her menstrual cycle?		□No □Yes At what age_____
Has she experienced problems?		□No □Yes Explain_____

Does your child attend school/day care? □No □Yes Where _____
If so, how is their behavior in school? □Excellent □ Average □Not good Explain_____
How are their grades? □ Excellent □ Average □ Failing Explain_____
On average, how many hours/day does your child spend in front of a screen*? TV, Computer, Video Game* _____*hrs/day*
Do you have concerns about your child's weight? □ No □Yes Explain_____
Does your child routinely exercise or engage in physical activity? □No □Yes Explain_____
Has your child experienced on going constipation? □ No □ Yes Explain_____
Has your child had any unusual feeding/dietary problems? □No □ Yes Explain_____

Has your child experienced any of the following? If yes, please explain below.

Frequent Ear Infections	□	Yes	□	No	Wheezing/ Asthma	□	Yes	□	No	Diabetes	□ Yes □ No
Other Problems with ears or hearing	□	Yes	□	No	Bronchitis/ Pneumonia	□	Yes	□	No	Fevers	□ Yes □ No
Chronic or recurrent skin problems	□	Yes	□	No	Lung/Breathing Issues	□	Yes	□	No	Headaches	□ Yes □ No
Nasal Allergies	□	Yes	□	No	Abdominal Pain	□	Yes	□	No	Chicken Pox	□ Yes □ No
Problems with Eyes/vision	□	Yes	□	No	Bladder or Kidney Infections	□	Yes	□	No	Bedwetting 5+yrs old	□ Yes □ No

If yes, please explain:_____

Please explain any other medical or social history that you consider important: _____
_____
_____
_____
_____

CURRENT MEDICATION (including vitamins, herbs, and over-the-counter)

Name	Dose	Name	Dose
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Has your child seen or consulted specialist or other health care providers?

□ Yes □ No If yes, please list:

_____

For Office Use Only

_____ Reviewed by Office Staff

_____

Name & Date Reviewed

_____ Reviewed by Clinical Staff

_____

Name & Date Reviewed

Approved _____

Denied _____ Explain:

_____

_____

_____

_____

_____

_____

_____

_____

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Letter sent regarding acceptance or denial _____

Date