

PLEASE PRINT ALL INFORMATION

MUST BE FILLED OUT COMPLETELY OR INSURANCE WILL NOT BE BILLED

PATIENT INFORMATION

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
NUMBER STREET APT# CITY STATE ZIP

PHONE# (____) _____ MAY WE LEAVE A MESSAGE YES NO
CIRCLE ONE

BIRTHDATE ____/____/____ SEX -- M F CHILD'S SSN _____
MONTH DAY YEAR CIRCLE ONE

SIBLINGS _____

PARENT INFORMATION Email address _____

MOTHER _____ SSN _____
LAST FIRST MIDDLE

ADDRESS _____
NUMBER STREET APT# CITY STATE ZIP

PHONE Home(____) _____ Work (____) _____ Cell (____) _____

DATE OF BIRTH _____ EMPLOYER _____
NAME ADDRESS

FATHER _____ SSN _____
LAST FIRST MIDDLE

ADDRESS _____
NUMBER STREET APT# CITY STATE ZIP

PHONE Home (____) _____ Work (____) _____ Cell (____) _____

DATE OF BIRTH _____ EMPLOYER _____
NAME ADDRESS

EMERGENCY CONTACT _____
NAME PHONE RELATION

WHO MAY WE RELEASE INFORMATION TO?
Name Relationship DOB

OVER

MEDICAL INSURANCE INFORMATION (PLEASE PROVIDE PROOF OF INSURANCE)

MUST PRESENT INSURANCE CARD AT EACH VISIT

IF YOU DO NOT HAVE CURRENT INSURANCE CARD YOU WILL BE RESPONSIBLE FOR PAYING ALL CHARGES AT THE TIME OF SERVICE. MUST BE FILLED OUT COMPLETELY OR INSURANCE WILL NOT BE BILLED.

PRIMARY INSURANCE _____
NAME ADDRESS

ID# _____ GROUP# _____ PARENT _____
WHO CARRIES INSURANCE

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH OF PERSON CARRING INS. _____

EFFECTIVE DATE OF INSURANCE _____ SSN _____
PERSON WHO CARRIES INSURANCE

SECONDARY INSURANCE _____
NAME ADDRESS

ID# _____ GROUP# _____ PARENT _____
WHO CARRIES INSURANCE

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH OF PERSON CARRING INS. _____

EFFECTIVE DATE OF INSURANCE _____ SSN _____
PERSON WHO CARRIES INSURANCE

MEDICAID/CARE SOURCE ID# _____

FOR THE BEST TREATMENT OF YOUR CHILD, ARE THERE ANY SPECIAL CIRCUMSTANCES THAT WE NEED TO KNOW ABOUT?

AUTHORIZATION: I hereby assign payment of any and all benefits to be made directly to **COPC (CENTRAL OHIO PRIMARY CARE PHYSICIANS, INC.)** and authorize the release of any information necessary to process claims. I understand that I am responsible for any and all charges not covered by insurance. **I have been made aware that missed appointments may result in a charge of half the fee for that particular service, this may be charged to me and that my insurance company will not pay for this charge. Copays not paid at time of service may be subject to a processing fee.**

PARENT SIGNATURE DATE

TREATMENT IN PARENTAL ABSENCE: I give Professional Pediatrics, Inc. permission to treat _____ in my absence. I remain responsible for all charges incurred.
CHILD'S NAME

PARENT SIGNATURE DATE

I HAVE BEEN OFFERED THE
NOTICE OF PRIVACY PRACTICES FOR COPC

X _____ X _____
SIGNATURE DATE

Patient Name _____ Birth Date _____ Date First Seen _____

Patient Address _____ Home Phone # _____

Race _____ Sex _____ Soc Sec# _____ Hospital _____

Age

Health

Family History

Mother			
Father			Tuberculosis _____ TBC Contacts _____
Sibling			Allergy _____
Sibling			Diabetes _____ Convulsive Disease _____
Sibling			Mother's Blood Type _____ RH _____ Baby's Blood Type _____

Birth and Development

Term _____ Delivery _____ Birth Weight _____

Condition at Birth _____ Apgar Score _____

Condition 1st week _____

Feeding _____ Cyanosis _____ Convulsions _____ Jaundice _____

Sat Up _____ Stood _____ Walked _____ Words _____

Short Sentences _____ First Teeth _____ Bladder _____ Bowel _____

Feeding History

Breast _____ Formula _____ Vitamins _____

Soft Food _____ Present Diet _____ Feeding Habits _____

Appetite _____ Likes _____ Dislikes _____

Vomiting _____ Stools _____ Sensitivity _____ Hives _____

Illnesses

Pertussis _____ Measles _____ Rubella _____ Mumps _____

Chicken pox _____ Scarlet Fever _____ Diphtheria _____ T and A _____

Operations _____ Allergy _____ Appendix _____ Glands _____

Rheumatic fever _____ Otitis _____ Colds _____ Tonsillitis _____

Constipation _____ Diarrhea _____ Asthma _____

Medical Information Summary

Today's Date ____/____/____

New Patient Established Patient

Child's Full Name _____

Referred by _____

Child's Date of birth ____/____/____

Child's Sex M F

Doctor (circle) Hestand Wheasler Muresan Buendia

Pregnancy/Birth History

(Complete if child <5 yrs old or significant history)

Mother's age at delivery _____

Month prenatal care began _____

Pregnancy Complications:

- Medications _____
- Infections _____
- Diabetes _____
- Preeclampsia _____
- Multiple Gestations _____
- Other _____

During pregnancy, the child's mother:

Smoked--How much? _____

Drank alcohol--How much? _____

Birth/Newborn Complications/:

- Cesarean _____
- Other _____

Premature? - How early? _____

Child's Family History

Unknown

Check the diagnoses given to the child's relatives.

Specifically-siblings, parents, grandparents, cousins, aunts or uncles.

- ADD
- Allergies
- Anemia
- Asthma
- Blood Disorder/Sickle Cell
- Cancer
- Diabetes
- Gastrointestinal disorder
- Heart disease before age 55
- High Blood Pressure
- High Cholesterol
- Learning Disability
- Mental retardation
- Psychiatric Illness (Depression, addiction, etc)
- Seizures/epilepsy
- SIDS (crib death)
- Stroke before age 55
- Sudden Death before age 50
- Other _____

Child's Medical History

Unknown

Hospitalizations:

No Significant Medical History

Age _____

Age _____

This Child has been DIAGNOSED with:

- ADD/ADHD Age _____
- Allergies/Hay fever Age _____
- Asthma Age _____
- Blood Disorder/Sickle Cell Age _____
- Broken Bones-Detail below Age _____
- Cancer-Type _____ Age _____
- Chicken Pox Age _____
- Developmental Delay Age _____
- Diabetes Age _____
- Frequent Ear Infections Age _____
- Headaches/migraines Age _____
- Learning Disability Age _____
- Pneumonia Age _____
- Scoliosis (curved spine) Age _____
- Seizures/epilepsy Age _____
- Stomach Problems Age _____
- UTI/Bladder infection Age _____
- Other _____
- HeartDisease _____ Age _____

Child's SURGERIES

- None
- Appendectomy Age _____
- Adenoidectomy Age _____
- Ear Tubes Age _____
- Eye Surgery Age _____
- Hernia repair Age _____
- Tonsillectomy Age _____
- Other Age _____

Current Medications:

Social/Environmental

Child lives w/:

Parent(s):

Together

Mother

Father

Relative _____

Other _____

Adopted

Smokers live in home with child?

Child attends daycare

Pets in the home? _____

Well water

Home built before 1960

Other _____

Allergies to Medicines:

