Pediatric New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Home Phone: _____ Mobile Phone: _____

Preferred (circle) : Home / Cell Email: _____ Gender: _____

Primary Pediatrician: _____ Phone: _____

Pediatrician Address: _____

Referring Provider: _____ Phone: _____

Referring Address: _____

Preferred Pharmacy: _____ Phone: _____

Preferred Pharmacy Address: _____

Parent 1 Name: _____ DOB: _____ Phone: _____ Email: _____

Address: _____

Occupation: _____ Marital Status: _____ Spouse: _____

Parent 2 Name: _____ DOB: _____ Phone: _____ Email: _____

Address: _____

Occupation: _____ Marital Status: _____ Spouse: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
- □ Decline Response
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race:
- □ Decline Response
- □ American-Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Other
- □ Decline Response

Preferred Language:

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

☐ Received ☐ N/A (only if you received the notice from ColumbiaDoctors previously)

myColumbiaDoctors Patient Portal Sign Up

Access your child's (or your) personal records securely, 24/7, on a computer, smartphone, or tablet. See brochure for details.

Patients 11 and younger: □ Send an invitation to join myColumbiaDoctors to the email address circled above for Parent 1 __/ Parent 2___. □ Opt out

Patients 12 and older: □ Send an invitation to join myColumbiaDoctors to the patient email address above. □ Opt out

Look for an email invite from noreply@followmyhealth.org and click the Registration link.

Insurance Plan Information Disclosure and Consent

ColumbiaDoctors will provide you with information regarding the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Portal Sign Up, Insurance Information).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

***Please refer to our website, columbiadoctors.org, for a list of insurances accepted by your provider.**

Medical and Social History

Reason for today's visit:

Is patient adopted? □ Y □ N *If 'Y', please answer the following to the best of your knowledge.*

Which pregnancy is patient? _____ Birth weight: _____ Born by: □ C-Section □ Vaginal Delivery

Weeks' gestation at birth? _____ If C-section, why? _____

Please describe any health problems the mother or patient experienced during pregnancy or after birth, if any:

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? □ Y □ N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL current medications, including over-the-counter, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Please list any past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Reason	Complications

Has the patient EVER had any of the following?

Anemia/Bleeding tendency	□ Y	□ N	Ear/Nose/Throat	□ Y	□ N
Asthma/Breathing problems	□ Y	□ N	Eczema/Skin disorder	□ Y	□ N
Behavioral problems	□ Y	□ N	Eye Disorder	□ Y	□ N
Blood Transfusion	□ Y	□ N	Growth disorder	□ Y	□ N
Bowel/Stomach problems	□ Y	□ N	Heart disorder/defect	□ Y	□ N
Cancer/Leukemia	□ Y	□ N	Kidney/Bladder problems	□ Y	□ N
Chicken Pox/Shingles	□ Y	□ N	Liver disease	□ Y	□ N
Developmental disorder	□ Y	□ N	Seizure or Epilepsy	□ Y	□ N
Diabetes	□ Y	□ N	Thyroid disorder	□ Y	□ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Parent:		□ Y □ N	
Parent:		□ Y □ N	
Sibling:		□ Y □ N	
Other:		□ Y □ N	

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to patient

Patient Social History

Does anyone living in your home smoke? □ Y □ N Do you have pets? □ Y □ N

Do you smoke? □Y □N □Never If Y, Packs/day _____ If N, previously? □Y □N Yrs smoked ____ Packs/day ___

Do you use other tobacco products? □Y □N Consume alcohol? □Y □N If Y, drinks/week _____

For Females: Menses? □Y □N If Y, at what age? _____

Review of Systems

Please indicate ALL that the patient has experienced within the past 6 – 12 months.

Constitutional

□Y□N Fever
□Y□N Chills
□Y□N Fatigue
□Y□N Feeling Poorly
□Y□N Sweats
□Y□N Weight Gain (___ Lbs)
□Y□N Weight Loss (___ Lbs)
□Y□N Unexp. Weight Change
□Y□N Sleep Disturbances
□ Other:

Head, Eyes, Ears, Nose, and Throat

□Y□N Vision Problem
□Y□N Decreased Hearing
□Y□N Double Vision
□Y□N Light Sensitivity
□Y□N Itchy Eyes
□Y□N Red Eyes
□Y□N Eye Pain
□Y□N Runny Nose
□Y□N Neck Stiffness
□Y□N Nosebleed
□Y□N Congestion
□Y□N Snoring
□Y□N Dry Mouth
□Y□N Flu-Like Symptoms
□Y□N Sore Throat
□Y□N Hoarseness
□Y□N Ringing in Ears
□Y□N Vertigo
□Y□N Earache
□Y□N Other:

Cardiovascular

□Y□N Chest Pain
□Y□N Palpitations
□Y□N Cold Extremities
□Y□N Cold Hands or Feet
□Y□N Irregular Heart Rhythm
□Y□N Other:

□Y□N Leg Swelling □Y□N Leg Pain w/ Walking

Respiratory

□Y□N Shortness of Breath	□Y□N Wheezing	□Y□N Coughing Up Blood	□
□Y□N Cough	□Y□N Shortness of Breath	□Y□N Coughing Up Sputum	
□Y□N Rapid Breathing	□Y□N Chest Congestion	□ Other:	

Gastrointestinal

□Y□N Abdominal Pain	□Y□N Diarrhea	□Y□N Change in Bowels	□Y□N Painful Swallowing
□Y□N Blood in Stool	□Y□N Black/Tarry Stools	□Y□N Vomiting Blood	□ Other:
□Y□N Vomiting	□Y□N Decreased Appetite	□Y□N Bowel Incontinence	
□Y□N Nausea	□Y□N Yellow Skin	□Y□N Rectal Pain	
□Y□N Constipation	□Y□N Trouble Swallowing	□Y□N Heartburn	

Neurological

□Y□N Headache	□Y□N Unsteady	□Y□N Numbness	□Y□N Tremor
□Y□N Dizziness	□Y□N Disorientation	□Y□N Tingling	□Y□N Memory Lapses/Loss
□Y□N Decreased Strength	□Y□N Confusion	□Y□N Seizures	□ Other:
□Y□N Poor Coordination	□Y□N Burning Sensation	□Y□N Fainting (Syncope)	

Musculoskeletal

□Y□N Joint Pain	□Y□N Limb Pain	□Y□N Muscle Pain	□ Other:
□Y□N Neck Pain	□Y□N Joint Swelling	□Y□N Muscle Weakness	
□Y□N Back Pain	□Y□N Muscle Cramps	□Y□N Leg Swelling	

Genitourinary

□Y□N Frequent Urination	□Y□N Pelvic Pain	□Y□N Painful Intercourse	□Y□N Heavy Period Bleeding
□Y□N Incontinence	□Y□N Nocturia	□Y□N Discharge- Vaginal	□ Other:
□Y□N Urinary Urgency	□Y□N Itching- Genital	□Y□N Vaginal Bleeding	
□Y□N Painful Urination	□Y□N Change in Libido	□Y□N Irreg. Monthly Cycles	

Integumentary

□Y□N Rash	□Y□N Skin Wound	□Y□N Unusual Growth	□Y□N Skin Cancer
□Y□N Dry Skin	□Y□N Change in A Mole	□Y□N Itching	□ Other:

Psychiatric

□Y□N Depression	□Y□N Anxiety	□Other:

Hematologic/Lymphatic

□Y□N Easy Bruising	□Y□N Easy Bleeding	□Y□N Swollen Lymph Nodes	□ Other:

Endocrine

□Y□N Excessive Thirst	□Y□N Heat Intolerance	□Y□N Changes- Skin
□Y□N Cold Intolerance	□Y□N Changes- Hair	□ Other:

OFFICE USE ONLY:

Provider Signature: _____ Date: _____