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

Office Use Only
MRN #: ______
Name: ______
Age: ______ Height: ______
Weight: ______ BP: ______
If female, age of first menses: ______

Name of person completing form: ______ Relationship (if not patient): ______

Chief Complaint
Reason for today's visit: ______

Symptoms/complaints and date of onset: ______

Pain severity: *(Check box)*

No pain	1	2	3	4	5	6	7	8	9	10	Most extreme
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Describe your pain: *(Check all that apply)* ☐ *Sharp* ☐ *Dull* ☐ *Throbbing* ☐ *Burning* ☐ *Tight* ☐ *Tingling* ☐ *Other:* ______

Pain occurs: *(Check all that apply)* ☐ *At rest* ☐ *With activity* ☐ *At night*

What do you do to reduce the pain? *(Check all that apply)* ☐ *Medicine* ☐ *Ice* ☐ *Heat* ☐ *Rest* ☐ *Elevation*

The problem is: ☐ *Improving* ☐ *Worsening* ☐ *Stable*

Describe other symptoms (if any) associated with this problem: ______

Is there a family history of this problem? ☐ *Yes* ☐ *No*

If this is an injury, please explain how it occurred: ______

If you have seen other doctors (including in an ER) for this problem, please fill out the below section:
Provider name: ______ Treatment given: ______
Provider name: ______ Treatment given: ______
Provider name: ______ Treatment given: ______

Social History
What is your child's grade in school, if applicable? ______ Does he/she attend a special needs facility? ☐ *Yes* ☐ *No*
If yes, please specify: ______

Languages spoken at home: *(Check all that apply)* ☐ *English* ☐ *Spanish* ☐ *Other:* ______

Who lives at home? ______

Does your home have: *(Check all that apply)* ☐ *1 story* ☐ *2 stories* ☐ *3+ stories* ☐ *Entrance steps* ☐ *Elevator*

Frequency of exercise/organized sports: ☐ *Daily* ☐ *Weekly* ☐ *Monthly* ☐ *Gym class only* ☐ *Rarely/never*

Specific type of exercise/sports that your child plays: ______

Please specify if your child receives the following: *(Check all that apply)*

Is your child enrolled in Early Intervention of Birth to 3? ☐ *Yes* ☐ *No*

Physical therapy: ☐ *Yes* ☐ *No* Frequency: ______________________________ School based: ☐ *Yes* ☐ *No*

Speech therapy: ☐ *Yes* ☐ *No* Frequency: ______________________________ School based: ☐ *Yes* ☐ *No*

Occupational therapy: ☐ *Yes* ☐ *No* Frequency: ______________________________ School based: ☐ *Yes* ☐ *No*

Describe any braces/orthotics your child uses, including pattern of use: ______________________________

____

Developmental Data

At what age did your child first do the following?

Walk: ____________ Sit: ____________ Stand: ____________

Please list any special concerns you have for your child's development: ______________________________

____

____

Provider Information

Please fill this section out for any additional providers your child sees

Additional provider's name: ____________________ Phone number: ____________________

Address: ____________________ Fax number: ____________________

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*

Additional provider's name: ____________________ Phone number: ____________________

Address: ____________________ Fax number: ____________________

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*

Required Information

Did this injury happen while working? ☐ *Yes* ☐ *No* Does this injury relate to an auto accident? ☐ *Yes* ☐ *No*

Is this injury related to a pending lawsuit? ☐ *Yes* ☐ *No*

____________________ ____________________

Reviewed by (provider) **Date**

____________________ ____________________

Parent/Guardian signature **Date**

Scan Folder: Registration Form