REGISTRATION FORM

VICTOR HEALTH ASSOCIATES
6532 ANTHONY DRIVE, SUITE A
VICTOR, NY 14564

Josephine Barrett, M.D.
Kevin D. Penird, M.D.
Brian E. Piotrowski, M.D.
Philip S. Meaker, M.D.

Today's Date ________________

MINOR PATIENT INFORMATION

First Name ________________________ MI ____ Last Name ____________________________

Birth Date ___/___/______ SS# ___-____-______ Gender ___M ___ F

Address ____ City _______________ State _______ Zip _______________

Home Phone (____) ______________ Cell Phone (____) ________________ Work Phone (____) ________________

LAST Primary Care Physician __________________________ Reason for Transfer __________________________

Current School / College __________________________ ☐ N / A Grade / Year of Study _______________

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Employment Status ☐ Full Time ☐ Part-Time ☐ Retired ☐ Unemployed Employer ____________________

Student Status ☐ Full Time ☐ Part-Time ☐ N/A

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Primary Language ☐ English ☐ Spanish ☐ French ☐ Other __________

Race ☐ White ☐ African American ☐ Asian ☐ Indian ☐ Pacific Islander ☐ Decline

Insurance Information

PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. The parent/guardian who is present for office visits is the Billing Guarantor, please see back for financial responsibility.

Primary Insurance

Insurance Company ______________________________

Patient ID # ____________________ Suffix ____________

Group # ____________ Effective Date ____________

Plan Type ________ PCP Listed with Plan: ______________

Select: ☐ Deductible: $______ ☐ Copay: $______

Subscriber Information ☐ Patient is Subscriber

Name ______________________ DOB ____________

Subscriber ID # ________________ Gender __ M __ F

Patient Relation to Subscriber: ____________

Secondary Insurance ☐ No Other Medical Insurance Coverage

Insurance Company ______________________________

Patient ID # ____________________ Suffix ____________

Group # ____________ Effective Date ____________

Plan Type ________ PCP Listed with Plan: ______________

Select: ☐ Deductible: $______ ☐ Copay: $______

Subscriber Information ☐ Patient is Subscriber

Name ______________________ DOB ____________

Subscriber ID # ________________ Gender __ M __ F

Patient Relation to Subscriber: ____________

Parent/Guardian Information:

***If a Parent/Guardian wishes to authorize another individual(s) to bring in patient for treatment please complete: Consent to Treat Form**

Parent/Guardian Full Name ____________________________ Relation ____________

Home Phone __________ Cell Phone __________ Address (If different) ______________________________

☐ Please check if person completing form

Parent/Guardian Full Name ____________________________ Relation ____________

Home Phone __________ Cell Phone __________ Address (If different) ______________________________

☐ Please check if person completing form

Office Use Only:
ACCT #:
Received Date/Initials:
Reviewed Date/Initials:

Please continue registration form on back of page.

FINANCIAL RESPONSIBILITY, OFFICE POLICY, & ASSIGNMENT OF BENEFITS

I directly assign all medical/surgical benefits to Victor Health Associates and authorize the office to release all information necessary to secure the payment of benefits.

BILLING GUARANTOR

The parent and/or legal guardian who completes and signs this form will be assigned as the Billing Guarantor for this account, and is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that payment of all medical care is due at the time of service and that if the parent or authorized individual presenting the child for care is not the designated Billing Guarantor, I agree to make arrangements prior to the visit to ensure payment is collected. See paragraph below concerning the "Presenting Parent." I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

DIVORCE/CHILD CUSTODY

Victor Health Associates will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since Victor Health Associates is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at the office is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. The office will still collect all applicable co-pays, coinsurance, deductibles, and outstanding balances at the time of service from the Presenting Parent even if the Presenting Parent is not the main insurance policy holder or Guarantor. If a parent/guardian has authorized another individual to accompany the child, this person must present the payment. Upon request, Victor Health Associates will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

ADDITIONALLY, I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. Copayments and coinsurance are due and payable at the time of the visit, as well as charge estimates for deductible plans. (This rule is part of your insurance company contract). A fee of $25 may be assessed if payment is not made at the time of service and a $25 fee will be charged for any returned checks.
2. Missed appointments, as well as cancellations and re-schedules within 24 hours of the appointment time, may result in a charge of $25. Additionally, multiple missed appointments could result in discharge from the practice. New patients will not be charged; however, we will not extend a second appointment to be scheduled.
3. Non-Covered Services are those that may not be covered under certain insurance plans or services provided to individuals without insurance or that are covered by an insurance the providers do not participate with (i.e. Medicaid). If I have no insurance coverage or if my insurance coverage is provided by a company other than one that Victor Health Associates accepts assignment from (including primary or secondary coverage), the cost of all services (or any remaining cost after submission to a policy we do participate with) will be the responsibility of the patient/parent/guardian/guarantor.
4. It is the patient responsibility to inform the office of any changes to contact information or insurance, as well as present a current insurance card at every visit. It is also the responsibility of the patient to provide their insurance with all necessary information needed for the office to bill on their behalf, this includes designating a provider as their PCP if required by their policy. *The full office Financial Policy is available by request.*

I have read and understand the above, and I certify that the information I have provided on this form and any other office forms is correct. I have been given a copy of the office Notice of Privacy Practices.

BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

Billing Guarantor Name (print)		**Relation to Patient**
Address / City / State / Zip		**Date of Birth** (mm/dd/yyyy)
Cell Phone	**Home Phone**	**Work Phone**
Billing Guarantor Signature		**Todays Date** (mm/dd/yyyy)

Effective Date: January 1st, 2016
Reviewed: 01/02/2020, 01/03/2017

NOTICE OF PRIVACY PRACTICES

Victor Internal Medicine & Pediatrics, PC
Lauren Brugnoni, Privacy & Security Officer 585-924-2100

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart on a computer known as an electronic health record/personal health. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. Text reminders are also available.

5. Check-In. We may use and disclose medical information about you by having you provide demographic information when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Copy of this Notice. You have a right to notice of our duties with respect to your health information, including right to a paper copy of this Notice. If you would like to have a more detailed explanation of these rights or if you would like to exercise one of these rights, contact our Privacy Officer.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Effective Date: January 1st, 2016

Reviewed: 01/02/2020, 01/03/2017

Victor Health Associates
Specialists in Pediatrics and Internal Medicine

6532 Anthony Drive, Suite A
Victor, New York 14564
Telephone: (585) 924-2100
Fax: (585) 398-1217

Authorization for Release of Medical Information

in order for us to process this request, complete all sections in blue or black ink. **Incomplete or inaccurate forms will not be accepted**.

Patient Name:______________________________ Date of Birth: ______________

Address: ____

City: ______________ State:_______ Zip: ______________

Phone: (_____) _______-__________ SS #: ______________

I authorize *Victor Health Associates* to obtain information from:

Name of Provider / Facility: ______________________________

Address: ____

City: ______________ State:_______ Zip: ______________

Phone: (_____) _______-__________ Fax: (_____) _______-__________

PURPOSE FOR THIS REQUEST: *(Check one)* ____Transfer of Care ____Health Care ____Other (specify): ________

INFORMATION TO BE DISCLOSED ***Please answer all by checking Yes or No to the right of each question***

- including alcohol/drug related information ___**Yes** ___**No**
- including information related to treatment for sexually transmitted diseases ___**Yes** ___**No**
- including mental health related information, such as depression, anxiety ___**Yes** ___**No**

Please Check #1 or #2 or #3:

☐ **1) Pertinent Records**

☐ **2) Other** ______________________________

☐ **3) No previous physician medical records to obtain.** ***Explain:***____________________
____

AUTHORIZATION VALID FOR: (Check One)

☐ This request only.

☐ One year from the date of this authorization **OR** through ________ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I **understand that**

- **My right to healthcare treatment is not conditioned on this authorization.**
- **I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form., except where a disclosure has already been made in reliance on my prior authorization.**
- **If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.**
- **Release of HIV– related information requires additional authorization.**

I further realize that under NYS Health Law, Sec.17, charging for copies of medical records is permissible, and that the office will charge $0.75/page.

____
Signature of Patient / Legal Representative Date

Print Name and Relationship to Patient (If requester is not the patient): ________________________

CONSENT FOR TREATMENT OF MINORS IN ABSENCE OF PARENT(S) OR LEGAL GUARDIAN

Name of Minor: ________________________ **Birth date:** ______________________ **Age:** ________

Please list Name and Contact Phone # for all parent/legal guardians of above named patient:

Parent/Guardian Completing Form: _____________________________ Relation: _____________ Phone #: _____________

Parent/Guardian Name: ____________________________________ Relation: _____________ Phone #: _____________

Parent/Guardian Name: ____________________________________ Relation: _____________ Phone #: _____________

I, the undersigned, am one of the legal guardians or parents with legal custody of the minor named above. I know that for the following reasons I may not be available to personally authorize medical care for said minor.

I hereby give my consent and authorization for any medical care that Victor Health Associates (The Practice) so determines as advisable, in the best judgment of health care providers. This care may include: scheduling appointments, accompanying child to appointments, consenting to medical procedures, emergency or non-emergency diagnostic procedures or tests, hospitalization, immunizations, mental health examination or treatment, **payment for medical care - Payment is due at the time of service by the individual present with minor patient.*

In my absence, I would like the health care provider to discuss the matter with the adults designated below. I authorize those persons, insofar as the law of New York State permits me to do so, to enter in to the decision, to convey to the provider my consent, and to consent to said treatment.

I hereby authorize the health care provider to discuss in full with those persons designated any medical information that is required to help the informed consent of the persons so designated. I have made and will make Victor Health Associates aware of any important medical facts to help health care providers in deciding what treatment is to be given. *This does not authorize the listed individuals to sign further authorization forms on behalf of a minor patient to obtain or release protected health information.*

I hereby hold harmless any health care provider of Victor Health Associates from any liability resulting from the failure to obtain consent from me as parent of the minor and from any other parent. It is my intent that the person or persons appointed herein shall be able to act in my stead in making such decisions.

I hereby appoint one person from the following list to be chosen in the order of priority listed, when the persons identified as parent/guardian of minor patient are not reasonably available, willing or competent to participate in the health care decision-making concerning the minor:

Name: ______________________________ Phone: ______________________________

Relation: ______________________________ Address: ______________________________

____

Name: ______________________________ Phone: ______________________________

Relation: ______________________________ Address: ______________________________

____

The period of time over which this authorization exists begins at signing and ends as follows:

☐ until ______/______/______

OR

☐ until revoked by a parent/guardian in writing, or another form is submitted, or the child reaches the age of emancipation.

______________________________ ______________________________ ____________________

Signature of Parent/Guardian | Printed name of Parent/Guardian | Date

______________________________ ______________________________

Signature of Witness | Printed name of Witness (must not be family member or listed above)

VICTOR HEALTH ASSOCIATES

WWW.VICTORHEALTHASSOCIATES.COM

PEDIATRIC PATIENT & FAMILY HISTORY FORM

Today's Date: _____/_____/________

Patient Full Name: __________________________________ Patient DOB: _____/_____/_______ Gender: M F

PATIENT MEDICAL HISTORY - ***Complete all Sections***		
1. Please list any patient hospitalizations:	☐ None	☐ Yes, Specify Reason(s)/Date(s):
2. Please list any major medical problems /surgeries:	☐ None	☐ Yes, Specify Problem(s)/Date(s):
3. Current prescription and OTC medications LIST ALL:	☐ No Rx	☐ No Over the Counter ☐ Yes, SPECIFY BELOW
3a. ☐ Prescription Medications (Include dosage/prescriber):		3b. ☐ Over the Counter Medications (Include dosage):
4. Patient Allergies / Reactions:	☐ None	☐ Yes, Specify:
5. Assistive Devices (Cane, Wheelchair, Hearing Aid, Other):	☐ None	☐ Yes, Specify:
6. Patient Enrolled in Daycare/ School/ Program?	☐ None	☐ Yes, Specify Location /Grade:
7. Previous Primary Care / Pediatrician Name:		Date of Last Visit: _______/______/_________

FAMILY HEALTH HISTORY - ***Complete at least one selection for each family member listed***									
Adopted? (circle) Yes No **Number of Siblings: ________**	MOTHER	FATHER	SISTER	BROTHER	GRANDMA	GRANDPA	AUNT	UNCLE	**Notes/Comments**
Deceased? (age/cause)	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	
Birth Defect	☐	☐	☐	☐	☐	☐	☐	☐	
Bleeding Problem	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer-**Type?**	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes – **Type?**	☐	☐	☐	☐	☐	☐	☐	☐	
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Attack/Disease	☐	☐	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	
Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	
Seizure	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	
Blindness/Deafness **(Specify)**	☐	☐	☐	☐	☐	☐	☐	☐	
NO SIGNIFICANT MEDICAL HISORY	☐	☐	☐	☐	☐	☐	☐	☐	

Signing below certifies that all information is accurate and completed to the best of your knowledge and signor is a legal parent/guardian.

Name of Person Completing Form: _____________________________ Relation to Patient: _________________

Signature: ____ Date Signed: ______/_______/________