ColumbiaDoctors

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: __________________