Silver Sage Center for Family Medicine

Andrew Pasternak, M.D., Teresa Angermann, D.O., Jason Crawford M.D., Melanie Perl A.P.R.N.

Silver Sage
CENTER FOR FAMILY MEDICINE

PEDIATRIC PATIENT INFORMATION SHEET

Name

_____
Last First MI Date of Birth

Physical Address_____
Address City State Zip

Mailing Address_____
Address City State Zip

Patient Phone_____ Cell_____ Work _____

Parent E-Mail_____ Sex: M F

Social Security_____ Race_____ Ethnicity_____

Parent/guardian Name(s):_____

Emergency Contact: _____
Name Phone Relationship

What is the best means to contact you: (Please circle one) E-mail Home phone Cell phone or Mail?

Parent Employment Information

Employer: _____

Employer Address: _____

Spouse/Parent: _____ Occupation:_____

Employer: _____ Work Phone: _____

Insurance Information for Child

Name of Subscriber: _____ Relationship to patient: _____

Birth Date of Subscriber: _____ Social Security #: _____

Name of Employer: _____ Work Phone: _____

Insurance Co: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Subscriber Name: _____

Employer: _____ Subscriber D.O.B: _____

Relationship to patient: _____

I understand that co-payments are due at the time of visit. I authorize payment of medical benefits from my insurance company to Silver Sage Center for Family Medicine. I also authorize the release of any medical information necessary to process any medical claim. **We bill insurance as a courtesy to you. You realize that you are responsible for any balance accrued at the time of visit should your insurance company not cover/pay. You acknowledge receipt of the privacy policies and practices notice (paper copy available by request).**

Signature: _____ Date:_____

Is there a friend of family member that we may disclose your medical information with? Name and relation:

_____

How did you hear about us? _____

We do not discriminate against anyone regardless for color, race, creed or physical ability.

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PATIENT INFORMATION SHEET

Name _____
Last First MI Date of Birth

Physical Address _____
Address City State Zip

Mailing Address _____
Address City State Zip

Patient Phone _____ Cell _____ Work _____

E-Mail _____ Sex: M F Marital Status: S M D W

Social Security _____ Race _____ Ethnicity _____

If Minor, Parent Name: _____

Emergency Contact: _____
Name Phone Relationship

What is the best means to contact you: (Please circle one) E-mail Home phone Cell phone or Mail?

Employment Information

Employer: _____

Employer Address: _____

Spouse/Parent: _____ Occupation: _____

Employer: _____ Work Phone: _____

Insurance Information

Name of Subscriber: _____ Relationship to patient: _____

Birth Date of Subscriber: _____ Social Security #: _____

Name of Employer: _____ Work Phone: _____

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Pediatric Health History Form

Child's Name: _____ Date of Birth: _____ Age: _____
Parents/Guardian: _____
Child's Previous Doctor: _____ Phone: _____
Present Health Concerns: _____
_____
Medication/Vitamins: _____
Herbs/Home Remedies: _____
Allergies/Reactions to Medications and Vaccinations: _____
_____

Pregnancy & Birth

Where was your child born? _____
Is the child yours by : __ Birth __ Adoption __ Stepchild __ Other: _____
Please indicate any medical problems during pregnancy __ None __ Specify: _____
_____
Delivery by __ Vaginal __ Caesarean If Caesarean, why? _____
Birth Weight: _____ Birth Length: _____ APGAR score: _____
Please indicate any medical problems during pregnancy. __ None. If premature, how early? _____
_____

Nutrition & Feeding

Was your child breastfed? __ No __ Yes If so, how long? _____
Has your child had any unusual feeding problems? __ No __ Yes If yes, specify: _____
_____
Milk intake now: Type __ Cow's Milk(__ 1% __ 2% __ Whole Milk) __ Soy Milk __ Rice Milk
Average ounces per day (Note: 8oz = 1 cup) _____

Sleep

Hours per night _____ Naps (Number and Length) _____
Any sleep problems: _____

Development

At what age did your child: Sit alone _____ Walk _____ Say words _____ Toilet train _____
Girls only: Age of first menstrual period: _____

Immunization/Infectious Disease: Please bring your child's immunization records to your appointment

Has your child had: __ Chickenpox __ Measles __ Rubella __ Meningitis __ Tuberculosis (TB)

Exposures/Habits: any concerns about lead exposure? (old homes/plumbing/peeling paint) __ N __ Y

Do any household members smoke: __ N __ Y
TV Hours per day _____ Computer hours per day _____ Video game hours per day _____

Past Medical History: Please describe any major medical problems and their dates:

_____

_____

_____

Hospitalizations (with dates): _____

_____

Broken bones or severe sprains: _____

_____

Social History:

Who lives at home?

Name	Age	Relationship

Are your child's parents __Married __Unmarried __Separated __Divorced If divorced/separated, when?___

Child care situation __ Parents __ Others (specify who and hours per day) _____

Concerns about your child: __Alcohol use __Tobacco __Sexual activity __Aggressive behavior __Drug use

Is violence at home a concern? __Yes __No Are there guns in the home? __Yes __No

School History:

Did/does your child attend preschool: __Yes __No

Current grade _____ Name of school _____

Any concerns about school performance? _____

If child is over 4 years old, does child have a best friend? __Yes __No

Sports/Exercise

Type of exercise _____ How often _____

Review of symptoms: Please indicate with an **X** if child has any of the following conditions:

Constitutional
__Fevers/chills
__Unexplained
__weight loss/gain

Cardiovascular
__Tires easily
With exertion
__Shortness of breath
__Fainting

Ears/nose/throat
__Unusually load voice/hard of hearing
__Mouth breathing/snoring
__Frequent runny nose
__Problems with teeth and gums

Respiratory
__Cough/wheeze
__Chest pain

Skin
__Rash
__Unusual moles

Allergy
__Hay fever/itchy eyes

Musculoskeletal
__Muscle/joint pain

Gastrointestinal
__Nausea/vomiting
__Diarrhea
__Constipation
__Blood in bowel movements

Blood/lymph
__Unexplained lumps
__easy bruising/bleeding

Eyes
__Squinting/cross-eyes
__Asymmetric gaze

Neurological
__Headaches
__Weakness
__Clumsiness

Psychiatric/Emotional
__Speech problems
__Anxiety/stress
__Problems with sleep/
nightmares
__Depression
__Bad temper/jealousy

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Adult Health History

Date: _____
Name: _____ D.O.B. _____ Gender M F
Occupation: _____ Highest level of education _____Birth place _____
Marital Status single/married/widowed/divorced/separated
Children (names/ages) _____

__NO KNOWN ALLERGIES

Allergies	Reaction

Medications and dosages:

Medical History

Do you currently have or have had in the past any of the following (check all that apply):

O Allergies (seasonal)	O Diabetes	O Anemia	O Cirrhosis	O Depression
O Asthma	O GERD (reflux)	O Heart attack	O Hepatitis	O Anxiety
O Benign prostatic hypertrophy	O Tension headaches	O Obesity	O Sexually transmitted disease	O Colon Cancer
O Gallstones	O Migraine headaches	O Osteoarthritis	O HIV	O Breast cancer
O Congestive heart failure	O Hyperlipidemia (high cholesterol)	O Osteoporosis	O Urinary incontinence	O Skin cancer
O COPD (emphysema)	O Hypertension (high blood pressures)	O Peptic ulcer disease	O Chronic sinusitis	O Prostate cancer
O Coronary artery disease	O Hypothyroidism	O Blood clots	O Dementia	O Lung cancer
O Other _____				

Surgical History

Have you had any of the following surgeries? If so, what year?

O Appendix_____	O Heart_____	O Hernia_____	O Stomach_____	O Breast augmentation/ reconstruction/biopsy
O Arthroscopy_____	O Cataract_____	O Joint replacement___	O Brain_____	O Thyroid_____
O Biopsy_____	O Gallbladder_____	O Sinus_____	O Hemorrhoids_____	O Hysterectony_____
O Other_____				

Social History

Have you ever smoked? Y N	Do you currently smoke? Y N	Are you interest in quitting? Y N
How much do you smoke? _____pack(s) a day for _____ years	How much alcohol do you drink in a week? _____	Do you use illicit drugs? Y N What kind? _____

Do you exercise? Y N If so, how often _____ What kind of exercise? _____

Do you have a living will? Y N Do you have a medical power of attorney? Y N

Do you want information on advanced directives? Y N

Family History

Disease	Father	Mother	Sibling	Grandparents	Children
Diabetes					
Cancer (if so what type)					
Heart disease/attack					
High blood pressure					
Stroke					
Thyroid disease					
Asthma					
Migraine headache					
Obesity					
Anemia					
Bleeding tendency					
Problem with anesthesia					
Depression/anxiety					
Bipolar					
Kidney disease					
Substance abuse					

Immunizations

Last Tetanus _____	Last Influenza_____	Last Pneumovax_____	Hepatitis B _____

OB/GYN History

Date of last menstrual period _____	Regular cycles? Y N	Pain/heavy bleeding with periods? Y N
Date of last pap smear _____	Need for birth control? Y N	Using birth control? Y N
Number of pregnancies _____	Number of births _____	Number of abortions _____
Number of miscarriages _____	Age of first menstrual period _____	Age of menopause _____

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1. I understand that if I do not pay my account with Silver Sage Center for Family Medicine in full, that my account may be assigned to a collection agency for collection.
2. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as 35% of the amount I owe to Silver Sage Center for Family Medicine. I agree that if my account is assigned to a collection agency, that Silver Sage Center for Family Medicine may add the amount of the collection agency's commission or fee to the amount that I owe Silver Sage Center for Family Medicine, and I agree to pay that additional amount.
3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for (medical/dental) services. I understand, for example, that if the unpaid balance that I owe to Silver Sage Center for Family Medicine is $1000, that Silver Sage Center for Family Medicine may add up to $350 to my account, and I agree to pay the sum of $1350 in such event.
4. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

_____ _____

Signature of Patient or Guarantor **Date**

_____

Printed Name