NEWBORN-AGE 2 HEALTH QUESTIONNAIRE

Patient's Name _____ **Age** _____ **DOB:** _____

Person filling out form _____

Pharmacy Name/City/Street: _____
(Please list a preferred pharmacy even if no medications are needed as we will add it to your chart for future needs.)

BIRTH HISTORY

Delivery: ( ) Vaginal ( ) Cesarean -Reason for C-Section _____
Apgar scores _____
Was Mother GBS positive ___Yes ___No. If so was she treated with antibiotics ___Yes___No
Hospital ( ) Home ( ) Birth Center ( )
Mother's Blood Type___
If you child is male did you circumcise ___Yes ___No
Did you child receive the following after delivery:
Erythromycin ___Yes ___No
Vitamin K ___Yes ___No
Hepatitis B ___Yes ___No
If child was born at home did she/he receive:
Newborn hearing screen ___Yes ___ No
PKU testing ___Yes ___No
Birth Weight: _____ Length: _____
Was the baby born within 2 weeks from the due date ___ Yes ___ No
Did the baby have to stay in the hospital for an extended time ___ Yes ___ No
If so please explain:
_____
_____

VACCINE HISTORY

Up to Date ___ Yes ___ No Please provide a copy of his/her vaccine record or sign a Release of Information to allow us to request them from previous provider.

PROBLEM LIST

Please put a check next to the problem and fill in the year diagnosed. If child does NOT have any of these problems, check NONE.

( ) Allergies _____ ( ) Eczema _____ ( ) Ear Infections _____
( ) Asthma _____ ( ) GERD _____ ( ) Developmental Delay _____
( ) ADD/ADHD _____ ( ) Seizures _____ **( ) NONE**
( ) Other _____

SURGICAL HISTORY

Please list all surgeries your child has had and give the year of that surgery.
1. _____ _____

2. _____ _____

Hospitalizations

Please list any hospitalizations your child has had, the reason, and the date.

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS

Please list any and all medications or pills that child is presently taking regularly or from time to time. If none, please state "none".

Drug Name/Dosage _____

_____

MEDICATION ALLERGIES

If child is allergic to any medication(s), please list them. Give Name of medication and type of reaction (Rash, Shock, Respiratory problems, GI upset, Unknown, Other). If none, please state "none".

_____

FAMILY HISTORY

Put a check next to the disease and circle the family member (M = Mother, F = Father, B/S = Brother or Sister, GP =Grandparent) who has had this disease.

( ) Allergies F M B/S GP ( ) Asthma F M B/S GP ( ) Seizures F M B/S GP
( ) Breast Cancer M S GP ( ) Diabetes F M B/S GP ( ) Melanoma **F** M B/S GP
( ) Colon Cancer F M B/S GP ( ) Heart Disease F M B/S GP ( ) Prostate Cancer F B GP

SOCIAL HISTORY

Birthplace: (State/Country) _____
Household members: Mother _____ Father _____ Brother(s) _____ Sister(s) _____
Others living in home _____ Smoking in the home? ____ Yes ____ No
Firearms in the home? ____ Yes ____ No Gun Locks __ Y __ N Pets in home __Y __N
History of physical/sexual abuse ___ Yes ___ No Explain _____
Potty Trained ___ Yes ___ No Infants: How many wet diapers daily ____ Bowel Movements _____
Is the child in daycare ___ Yes ___ No

DEVELOPMENTAL HISTORY:

Do you have concerns about your child meeting developmental milestones____Yes ____ No
(examples: walking, talking, skipping, eating with utensils, reading, etc.)

DIETARY HISTORY

( ) **Breast feeding** Duration: _____ minutes every _____ min/hour(s)
( ) **Formula** ( ) Enfamil ( ) Enfamil w/iron ( ) Similac ( ) Similac w/iron Other: _____
How much? _____ oz. every _____ min/hour(s)
( ) **Cereal** ( ) once a day ( ) twice a day ( ) three times a day ( ) more than three times a day
( ) **Baby foods**
( ) Vegetables – type: _____ times per day: _____
( ) Meats – type: _____ times per day: _____
( ) Fruits - type: _____ times per day: _____
Please list what your child drinks and how much daily: _____
Please list your child's favorite foods/snacks:

_____

Please list concerns and/or questions you would like to discuss during today's visit.

_____

_____

Cole Family Practice, LLC - Registration Form

Patient Information

First: _____ Middle: _____ Last: _____

□ Male □ Female

Date of Birth: _____/_____/_____ SS#:_____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H)_____(C)_____ (W)_____

Email address: _____

Emergency Contact: _____ Relation to patient: _____

Phone: _____

Employer Information:

Patients Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent or Financially Responsible Party (if different than patient)

First: _____ Middle: _____ Last: _____

□ Male □ Female

Date of Birth: _____/_____/_____ SS#: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H)_____ (C)_____ (W)_____

Relationship to Patient: _____

Primary Insurance

Insurance Name: _____Cardholders Relationship to Patient: _____

ID #: _____ Co-Pay Amount: _____

Secondary Insurance

Insurance Name: _____ Cardholders Relationship to Patient: _____

ID #: _____ Co-Pay Amount: _____

OFFICE POLICY

I authorize Cole Family Practice, LLC to furnish information to insurance carriers concerning my care. I agree to pay Cole Family Practice, LLC for all services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

SELF-PAY PATIENTS will be required to pay for your office visit before you are seen. However, you are responsible for any additional cost related to the visit. Federal Law requires that we bill every patient the same amount. We are not allowed to change billing based on whether or not patients have insurance.

INSURANCE PATIENTS – IT IS YOUR RESPONSBILITY TO:

- Provide us with updated and current insurance information at each visit.
- Provide us with updated contact information including phone numbers and address.
- Pay your deductible and/or copay at the time of service
- Pay for any services not covered by your insurance
- Make sure you have a current referral if your insurance requires one.

As a courtesy to our patients we will file all claims with your insurance carrier and provide them with any information necessary to process the claim.

YOU ARE RESPONSBILE FOR ALL SERVICES RENDERED – IF (FOR ANY REASON) YOUR INSURANCE DOES NOT PAY- THE BALANCE IS YOUR RESPONSIBILITY.

Unpaid Bills – A collection agency will be chosen to manage delinquent accounts. Once referred to collections, no assistance will be provided by our office. If your account is placed with a collection agency, you will be responsible for all collections and attorney's fees necessary to collect this debt.

CONSENT TO TREAT & MEDICAL RECORDS RELEASE AUTHORIZATION:

I authorize Cole Family Practice practitioners to provide treatment that they may deem advisable for my dependents and me. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment. I authorize Cole Family Practice to conduct urine drug screens as part of my assessment per the office policy. I authorize Cole Family Practice to obtain any previous medical records, for my dependents or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependents or me.

I have read and understand the above items regarding insurance, finance, responsibility, authorization of charges, consent, and medical records and agree to the terms and conditions related to each item.

_____ _____

Patient or Responsible Party Signature **Date**

Cole Family Practice, LLC – HIPAA/Permission From

The Health Insurance Portability and Accountability Act (HIPAA) require Cole Family Practice to notify patients regarding how their Protected Health Information is handled. Our HIPAA policy is posted in the Lobby. You have the right to review policy and take a copy of the policy. With your permission, we may disclose your Protected Health Information to a family member, close friend, or any other person that you identify.

I, _____, authorize Cole Family Practice to

release any personal information relating to my health care

☐ To No One

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

I have reviewed the HIPAA Notice of Privacy Practices for Cole Family Practice. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: _____

Patients / Guardian Signature: _____ Date: _____

Vaccination Informed Consent

I. I understand that vaccines are given to protect both the individual and the general population against catching and spreading certain serious infectious diseases. I recognize that reactions to vaccines sometimes do occur. The way that vaccines are given shall conform to recognized standards of medical practice in accordance with U.S. Department of Health and Human Services, Public Health Service's Recommendations of the Advisory Committee on Immunization Practices (ACIP), and the latest Report of the Committee of Infectious Diseases of the American Academy of Pediatrics.

II. I have a right to delay any vaccine until I feel that I am capable of making an informed decision and have been able to assess the benefits, risks, and alternatives. I am aware that prior to school/daycare entry that vaccines are not mandatory.

III. To exercise my right of informed consent, I may use all resources available to me to become more fully informed about vaccine contents, effectiveness, safety, and possible side effects.

IV. The Vaccine Information Statement (VIS) must be provided to me before the administration of any vaccine, but I may ask for a copy of any of the VIS at any time before the vaccine appointment date, so that I may have time to review and understand the content. I also may ask to review the vaccine package insert(s) to get more information about the particular vaccine(s), its content(s), effectiveness, contraindications and possible side effects.

V. At any time after a vaccine is administered, I may request a copy of the Vaccine Administration Record (healthcare providers are required to note the edition date of the VIS given to the patient, the date the VIS was given, the name, address and title of the individual who administers the vaccine, the date it was administered, and the vaccine manufacturer and lot number of the vaccine used) from my child's physician, to be provided within a reasonable amount of time.

VI. For school or daycare enrollment, one may be exempt from vaccination for medical or religious. Without a legal exemption, I understand that one must have begun a vaccine administration schedule in order to attend daycare or school.

VII. At any time after a vaccine is administered, I may file a VAERS incident report for vaccine reactions, with or without a physician's approval or signature. I may also review VAERS reported adverse events/surveillance data at: http://vaers.hhs.gov/

VIII. As long as vaccines have been administered in accordance with the guidelines put forth by the CDC and FDA, and the physician has not compromised the rights stated above, by making this informed decision I do not hold the health care provider liable for any potential negative outcome, whether it is from the giving or withholding of any or all vaccines.

Patient Name: _____

Parent Name: _____

Signature: _____ Date: _____

Cole Family Practice
226 Jackson Meadows Drive, Hermitage, TN 37076
615-874-3422 www.colefamilypractice.org

Release of Medical Records Authorization

Patient Name:_____

Date of Birth:_____

Requested records from:

Office Name:_____

Provider Name:_____

Office Number:_____

Please send most recent office notes and immunization record to
Cole Family Practice **Fax: (615)874-3465**

I understand no information may be disclosed by either agency to any individual or agency unless by written consent. I give my consent freely and voluntarily.

Patient/Parent Signature_____

Date_____

Cole Family Practice
226 Jackson Meadows Drive, Hermitage, TN 37076
615-874-3422 www.colefamilypractice.org