Lisa P. Allardice MD, F.A.A.P.
Mindy Scheible, NP-C
Diana Hess, CPNP
Carlie Frederick, APRN-BC

Pediatric Associates of LaGrange, P.C.

Today's Date: ______________

P A L S

Patient First Name: Middle Name: Last Name:

MARK THE NAME PATIENT GOES BY

Patient SSN: Patient DOB: Sex: M F

Bill Payer: Patient Lives With:

Address: Address:

City: State: Zip: City: State: Zip:

Mother's Cell Phone: - - Mother's Work Phone: - - Home Phone: - -

Father's Cell Phone: - - Father's Work Phone: - - Alt. Phone: - -

Mother's Name: Maiden Name: Mother's DOB:

Mother's Employer: Mother's SSN:

Father's Name: Father's SSN: Father's DOB:

Father's Employer:

Primary Insurance: Dad's Insurance Mom's Insurance Other:

Secondary Insurance: Dad's Insurance Mom's Insurance Other:

Number of people living in child's household Mother in Household: Y N Father in Household: Y N

Sibling: Age: Healthy: Y N

Sibling: Age: Healthy: Y N

Sibling: Age: Healthy: Y N

Sibling: Age: Healthy: Y N

Persons Allowed to bring child to office visits for treatment Relationship to patient

PEDIATRIC ASSOCIATES OF LAGRANGE, P.C.
LISA P. ALLARDICE, M.D., F.A.A.P.
DIANA L. HESS, CPNP

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Associates of LaGrange, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates of LaGrange's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates of LaGrange reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Associates of LaGrange's Privacy Officer at 205 Calumet Center Road, LaGrange, GA, 30241.

With my consent, Pediatric Associates of LaGrange may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Associates of LaGrange may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Pediatric Associates of LaGrange may e-mail and/or text to me appointment reminders and patient statements. I have the right to request that Pediatric Associates of LaGrange restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Pediatric Associates of LaGrange's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Associates of LaGrange may decline to provide treatment to me.

I authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Associates of LaGrange, P.C., for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

____
Signature of Parent or Legal Guardian

Date ____________________________

____
Print Name of Parent or Legal Guardian

____
Print Patient's Name

PATIENT MEDICAL HISTORY

PATIENT NAME: ___________________________

Please circle if your child has had any of the following:

Bronchiolitis	Kidney Disease	Blackout Spells	Congenital Heart Disease	Behavior Problems
Bronchitis	Kidney Infections	Brain Disease or Injury	Neurofibromatosis	Eye Problems
Persistent Cough	Problems Urinating	Cerebral Shunt	Tuberous Sclerosis	Skin Problems
Wheezing	Urinary Tract Infections	Headaches	Chicken Pox	Immune Problems
Whooping Cough	Urologic Malformations	Seizures	Mumps	Thyroid Problems
Allergies	Constipation	Staring Spells	Measles	Sleep Problems
Hay Fever	Diarrhea	Broken Bones	German Measles	Bleeding Problems
Sinusitis	Excess Weight Gain	Joint Problems	Malignancy or Bone marrow Transplant	Eating Problems
Scarlet Fever	Excess Weight Loss	High Blood Pressure	Solid Organ Transplant	Prematurity
Strep Throat	Frequent Vomiting	Treatment with medicine known to raise blood pressure	Poisoning	
Tonsillitis	Soiling Pants		Meningitis	
Bed Wetting	Stomach Ache			

Please specify any allergies your child has had in the past: ___________________________

Please list any medical problems, surgeries,specialists: ___________________________

Please list all medications currently taken: ___________________________

Hospitalizations: ___________________________

Circle if your child had any of the following with baby shots (immunizations): High Fever, Seizure, Leg Swelling, Uncontrollable Screaming, Other ___________________________

Pregnancy, labor, delivery and nursery: Was your pregnancy planned? Yes No

Circle if you had any of the following during pregnancy:

C-Section	Labor longer than 1 day	Hepatitis B or C	Other pain medicines
Reason for C-Section ________________	Early labor	Syphillis	Kidney infections
	Vacuum	Gonorrhea	Other infections
Spinal/Anesthesia	Forceps	High blood pressure	Medicines other than prenatal vitamins
Infection or fever during labor	Group B Strep	Alcohol or drug abuse	
Water leaking > 1 day	HIV	Cigarette use	Cigarette Exposure

Circle it the baby had any of the following problems:

Problem right after birth	Infection	Jaundice	Longer hosp stay than you
Breathing problems	Low sugar	IV or IV antibiotics	Low blood count or anemia
Feeding problems	Heart murmur	ICU	Tube, bag or mask to breathe

What was the child's birth weight? ____________ What was the child's Apgar scores? ___________
Was the baby full term? If not, how many weeks early? _________ If child stayed in the ICU, where and how long? ___________________________ Problems while in ICU? ___________________________
Any signs or symptoms of maternal/paternal depression since child's birth? Y/N Explain: ___________________________

Family History: ***Circle in anyone in your family has any of the following:***

Y/N High cholesterol	Y/N Gallbladder disease	Y/N Seizures	Y/N Eye problems	Y/N Birth defects
Y/N High blood pressure	Y/N Hepatitis B,C	Y/N Migraines	Y/N Deafness	Y/N Cancer
Y/N Rheumatic Fever	Y/N Thyroid disease	Y/N Asthma	Y/N Allergies	Y/N Early death
Y/N Kidney stones	Y/N Diabetes	Y/N Cystic Fibrosis	Y/N Eczema	Y/N Mental disease
Y/N Congenital kidney disease	Y/N Overweight	Y/N TB (Tuberculosis)	Y/N Skin problems	Y/N Mental retardation
Y/N Kidney disease	Y/N Excessive weight gain	Y/N Abnormal fingers or toes	Y/N Cleft lip or palate	Y/N Behavior problems
Y/N Ulcers	Y/N Height less than 5' 0"	Y/N Joint disease	Y/N Bleeding problems	Y/N Learning problems
Y/N Bowel disease (Ileitis)	Y/N Height greater than 6'4"	Y/N Crippling arthritis	Y/N Leukemia	Y/N Reading problems
Y/N Liver problems	Y/N Immune problems	Y/N Sickle cell disease	Y/N Abnormal teeth	Y/N Hyperactivity/ADD/ADHD
Y/N Alcohol problem	Y/N Stroke	Y/N Blindness	Y/N Down's Syndrome	Other____________

Y/N Heart Attack (man less than 40 years/ woman less than 50 years)

Revised 3/12/2015 Person Completing Form___________________________ Date ___________

Patient Name: ______________________________

Cholesterol Risk Assessment Questionnaire

1. Have your child's parents or grandparents been diagnosed with high cholesterol at less than 55 years of age? Yes No ____________
2. Have your child's parents or grandparents ever had a heart attack At less than 55 years of age? Yes No ____________
3. Does your child smoke? Yes No ____________
4. Have your child's parents or grandparents ever been diagnosed With heart disease, stroke or blood clot in the legs at less than 55 years of age? Yes No ____________
5. Has your child ever had an elevated blood pressure? Yes No ____________
6. Have your child's parents or grandparents ever had any heart surgery (angioplasty or bypass surgery) at less than 55 years of age? Yes No ____________

Parent Signature ______________________ Date __________

- ☐ Parent Signature______________________ Witness ______________________ Date ____________
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Patient Name:________________________________

Tuberculosis (TB) Risk Assessment

Circle Yes or No

Question			*If Yes, please explain
1. Is the child in close contact to a person with active TB disease?*	Yes	No	____________
2. Does the child have or is at risk to have HIV?	Yes	No	____________
3. Was the child or the child's parent born outside the US?	Yes	No	____________
4. Is the child exposed to a person in jail or a person who has been in jail in the past five years?	Yes	No	____________
5. Is the child exposed to a person who has HIV, who is homeless or who lives in nursing home or another group home?	Yes	No	____________
6. Is the child exposed to drug users or migrant farm workers?	Yes	No	____________
7. Does the child have a health problem that lowers the immune system?	Yes	No	____________
8. Does the child live in a community that has a high risk for TB?	Yes	No	____________
9. Has the child traveled to or had any visitors from any foreign country since the last visit?	Yes	No	____________
10. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest x-ray?*	Yes	No	____________

*** Call the Health Department**

Vision Risk Assessment Questionnaire

Circle Yes or No

Question			*If Yes, please explain
1. Has anyone in your child's family been diagnosed with congenital cateracts, retinoblastoma, metabolic disease, or ocular abnormalities?	Yes	No	____________
2. Has anyone in your child's family been diagnosed with amblyopia (blurred vision) or strabismus (lazy eye)?	Yes	No	____________
3. Has anyone in your child's family been diagnosed with epiphora (excessive watery eyes), photophobia (light sensitivity), ptosis (drooping of the upper eyelid), or anisocoria (unequal pupil size)?	Yes	No	____________
4. Has anyone in your child's family had glaucoma, eye surgery, or glasses	Yes	No	____________
5. Do your child's eyes appear unusual?	Yes	No	____________
6. Does your child seem not to see well?	Yes	No	____________
7. Does your child exhibit difficulty with near or distance vision?	Yes	No	____________
8. Do your child's eyes appear not to be straight?	Yes	No	____________
9. Do your child's eyelids droop or does one eyelid tend to close?	Yes	No	____________
10. Has your child ever had an eye injury?	Yes	No	____________

Parent Signature ______________________________ Date ____________

Please check the box and sign if there have been no changes to the above answers since the last checkup.

- ☐ Parent Signature____________________ Witness ____________________ Date ____________
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- ☐ Parent Signature____________________ Witness ____________________ Date ____________

Patient Name: ______________________________

Lead Risk Assessment Questionnaire

Circle Yes or No

			*If Yes, please explain
1. Does your child live in or often visit a house that may have been built before 1978?	Yes	No	________
2. Does your child live in or often visit a house that is being remodeled or is having paint removed?	Yes	No	________
3. Does your child live with or often visit another child that has an elevated blood lead level?	Yes	No	________
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it?	Yes	No	________
5. Does your child chew on or eat any non-food items like paint chips or dirt?	Yes	No	________
6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead?	Yes	No	________
7. Does your child receive medicines such as *greta, azarcon,kohl or pay-loo-ah*?	Yes	No	________

Risk Factors for Hearing Loss

1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay	Yes	No
2. Family history of permanent childhood hearing loss	Yes	No
3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion	Yes	No
4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis	Yes	No
5. Craniofacial anomalies, especially involving the ear and temporal bone	Yes	No
6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction	Yes	No
7. Syndromes associated with hearing loss or progressive or late-onset hearing loss	Yes	No
8. Neurodegenerative disorders or sensory motor neuropathies	Yes	No
9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis	Yes	No
10. Head trauma	Yes	No
11. Chemotherapy	Yes	No
12. Recurrent or persistent ear infection for at least 3 months	Yes	No

Parent Signature ______________________________ Date ______________

Please check the box and sign if there have been no changes to the above answers since the last checkup.

☐ Parent Signature______________________ Witness ______________________ Date ______________

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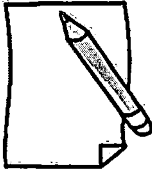
☐ Parent Signature______________________ Witness ______________________ Date ______________

Patient Name: ______________________________

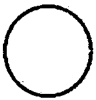


Developmental Drawing Sheet

Please use this sheet to allow your child to show us their creativity. This is not only fun for your child, but also allows us to observe fine motor and cognitive skills. Several age groups are listed. Find your child's age and ask them to complete the activities for that age. Remember to allow your child to practice these skills with you at home. Coloring is fun and great for your child's brain development. When you are done, draw a picture on the back of the page.

15 Months- 30 Months Old: Let your child use your pen and clipboard to have fun and scribble in the space below.

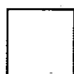
3 & 4 Years Old: Ask your child to copy the circle and cross pictured below & draw a person.



5 Years Old: Ask your child to draw a circle and cross, copy the square and triangle pictured below, print some letters and numbers, & draw a person.

CIRCLE:

CROSS:



Draw us a picture below

www.m-chat.org

Child's name ______________________ Date ______________________

Age ______________________ Relationship to child ______________________

M-CHAT-RTM (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

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