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

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: - -

A

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:

L

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

S

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

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	Eating Problems
Scarlet Fever	Excess Weight Loss	High Blood Pressure	marrow Transplant	Prematurity
Strep Throat	Frequent Vomiting	Treatment with medicine	Solid Organ Transplant	
Tonsillitis	Soiling Pants	known to raise blood	Poisoning	
Bed Wetting	Stomach Ache	pressure	Meningitis	

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
Infection or fever during labor	Group B Strep	Alcohol or drug abuse	prenatal vitamins
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)

Person Completing Form_____Date _____

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 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 _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

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Patient Name:_____

Tuberculosis (TB) Risk Assessment

Circle Yes or No

			*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

			*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 epiphoria (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 _____

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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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