1206 Brown St
Washington, NC 27889
252-946-4134
Fax 252-946- 2432

Medical History

Patient's Name: _____ Date of Birth: _____

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

The child lives with: ☐Mother ☐Father ☐Other: _____

Do other children live at home? Please write names, ages, and type of relationship:

_____

_____

_____

Who looks after the child regularly? _____

Has there been a major change in your family recently ?

_____

_____

Do you have any concerns about the ability to meet your child's basic safety needs, such as food, shelter, or transportation?

_____

_____

Have you had any experience or concern about domestic violence? ☐Yes ☐No

Do you or a member of your family have a history of alcohol or drug abuse? ☐Yes ☐No

Tobacco Exposure - Please list if there is a smoker in the home. If your child is over 13 years old, does he / she use tobacco products?

_____

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Was your child born full-term? ☐Yes ☐No If not, how early was the baby born?
Natural: _____ C-section: _____

Birth weight ? _____ Where was the child born?_____

Did the child go home with his/her parents ? _____ Did the baby stay in NICU? _____

Did the mother have complications with delivery? ☐No ☐Yes - please describe

_____

Has the patient had any hospitalizations? ☐No ☐Yes - please describe

_____

Has the patient had any surgery? ☐No ☐Yes - please describe

_____

Illnesses: Please list if your child had to go to the emergency room:

_____

_____

Medications: Please list any medication that your child is taking with a prescription or over-the-counter medication:

_____

_____

Allergies: Medications: _____

Food: _____

Environmental or seasonal allergies: _____

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Family History

Check the appropriate box:

				Maternal (mother)					Paternal (father)				
	Mom	Dad	siblings	Grand mother	Grand father	Aunt	Uncle	others	Grand mother	Grand father	Aunt	Uncle	others
Diabetes													
Heart													
Stroke													
Asthma													
Mental Illness													
High Blood pressure													
Cancer type:													
Sickle Cell Trait / Disease													
Other : What ?													

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MEDICAL AUTHORIZATION FORM

I. Family Information

Patient Name: _____ Date of Birth: _____

Mother: _____Phone :_____

Father: _____Phone: _____

II. Additional people who can bring the patient for treatment:

Name: _____Phone #: _____

Relationship to patient: _____

Name: _____Phone #: _____

Relationship to patient: _____

Name: _____Phone #: _____

Relationship to patient: _____

III . Permission for medical treatment: I authorize the person caring for my child or any other authorized adult to take my child to Washington Pediatrics, PA to seek medical treatment of any kind.

_____ _____

Parent Signature: Date:

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Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment to the above named doctors and the benefits specified herein and otherwise payable to me. I understand that I am fully responsible to the doctors for any charges not covered by my insurance.

Insured Name: _____Insurance: _____

Policy Number: _____

Birthdate of the insured: _____

Insured social security # : _____

Signature: _____

INFORMATION AUTHORIZATION

I authorize the transfer of any information, including diagnoses and records of any patient treatment Patient

Name: _____

Parent Signature : _____

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Patient Acknowledgment and Consent

I received a copy of Washington Pediatrics, PA About Notice of Privacy Practices, effective version _____. I give my consent to the uses and disclosure of my health information as indicated in the advertisement.

_____
Name of Patient or Representative

_____ _____
Signature of Patient or RepresentativePatient Representative Date

_____
Relationship

Please describe the representative authority to act on behalf of the patient: