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**Pediatric Patient Information**

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: F M

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mark if they are the same

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**We would like to scan your insurance card at your first visit so please bring it with you to the appointment.**

Primary Ins. Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Parent 1:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: (skip if same) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Parent 2:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: (skip if same) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

By signing this sheet I agree with the following statements:

- \* I have provided accurate demographic and insurance/billing information.
- \* I understand that it is my responsibility to contact Quality Orthopaedic Care, P.C. if I move, change insurance policies or have other changes to the information listed above.
- \* I authorize Quality Orthopaedic Care, P.C. to: bill my insurance company for services provided and if necessary release health information, to the insurance company to process my insurance claims.
- \* I request payment go to Quality Orthopaedic Care, P.C. for the services provided.
- \* I have received the following documents and understand it is my responsibility to review them.  
 Quality Orthopaedic Care, P.C. Notice of Privacy Practices Policy – included in this packet  
 Quality Orthopaedic Care, P.C. Financial Policy – included in this packet

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

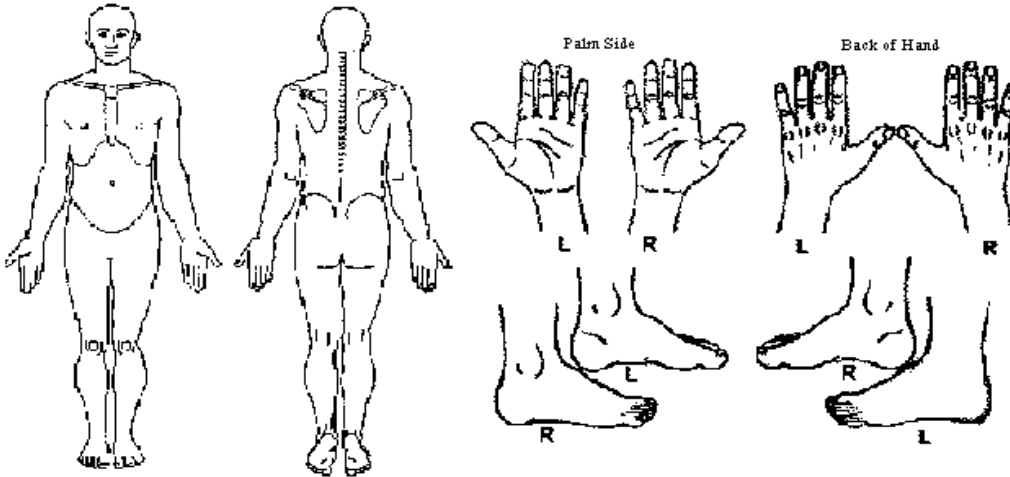
**Patient History and Physical Form**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What is the reason for this visit/what is the chief complaint? \_\_\_\_\_

What caused the problem? \_\_\_\_\_

Please mark on the diagram where the patient is having the problem:



Injury Date \_\_\_\_\_ or how long has this been a problem? \_\_\_\_\_ days weeks months years

Please mark the symptoms that apply:

- ◇ Pain ◇ Swelling ◇ Bruising ◇ Tingling ◇ Numbness ◇ Laceration/Bleeding ◇ Unstable/Weak
- ◇ Locking ◇ Popping ◇ Grinding ◇ Catching ◇ Other: \_\_\_\_\_

What is the severity of the symptoms? (1-10 rating, 10 is the most severe): \_\_\_\_\_

Past Treatment for this problem:

- ◇ Emergency Room ◇ Primary Care Doctor ◇ Physical Therapy ◇ Occupational Therapy ◇ Surgery
- ◇ Icing ◇ Heat ◇ Brace or Sling ◇ Other: \_\_\_\_\_
- ◇ Medications: \_\_\_\_\_

What has helped reduce the symptoms? \_\_\_\_\_

What makes the symptoms worse? \_\_\_\_\_

Is your child allergic to Latex? Y N

Is your child allergic to Penicillin or any Medications? Y N

Allergies – medication or other – type of reaction:

\_\_\_\_\_  
\_\_\_\_\_

**Patient History and Physical Form (continued)**

**Initials of Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ - required to identify all pages in record

**Current and past medical problems:**

	Circle One		please describe all yes responses
Eyes	Yes	No	_____
Ears Nose Throat	Yes	No	_____
Lungs, Breathing	Yes	No	_____
Digestion	Yes	No	_____
Bowel Problems	Yes	No	_____
Bladder Problem	Yes	No	_____
Diabetes	Yes	No	If yes, insulin dependent? _____
High Blood Pressure	Yes	No	_____
Bleeding Problem	Yes	No	_____
Balance Problems	Yes	No	_____
Numbness/Tingling	Yes	No	_____
Blackout/Fainting	Yes	No	_____
Psychological Problems	Yes	No	_____
AIDS	Yes	No	_____
Cancer (provide type)	Yes	No	_____
Arthritis	Yes	No	_____
Polio	Yes	No	_____
Tuberculosis (TB)	Yes	No	_____
Epilepsy	Yes	No	_____
Others not provided	Yes	No	_____

**Past injuries, hospitalizations and surgeries: (Please start with most recent)**

<u>Year</u>	<u>Injury\Illness\Surgery</u>	<u>Physician\Hospital</u>
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**Please list all current medication:**

<u>Medication</u>	<u>Reason for med</u>	<u>Dosage</u>
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**Has your child ever had difficulties with anesthesia?** Y N If yes, explain: \_\_\_\_\_

**Has your child been treated recently with antibiotics?** Y N If yes, when and why: \_\_\_\_\_

**Is there a family history of Malignant Hyperthermia?** Y N Unknown

(Condition triggered by exposure to anesthesia medications)

**Has your child ever had Methicillin resistant Staph Aureus?** Y N Unknown

(Staph/Bacterial infection resistant to antibiotic methicillin)

**Has your child ever had Vancomycin resistant Enterococcus?** Y N Unknown

(Bacterial infection resistant to antibiotic vancomycin)

**Family History: (Please list your immediate family members and their health status)**

	<u>Living</u>	<u>Age</u>	<u>Known Medical Conditions or Cause of Death</u>
Mother	Y N	_____	_____
Father	Y N	_____	_____
Brother/Sister	Y N	_____	_____
Brother/Sister	Y N	_____	_____
Father's Parents	Y N	_____	_____
Mother's Parents	Y N	_____	_____

**Child's height:** \_\_\_\_\_/\_\_\_\_\_ ft./in **Approximate Weight:** \_\_\_\_\_ lbs. **Dominant Hand:** Right Left

**Please list your child's activities:**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_