CNY FAMILY CARE PEDIATRIC PATIENT INTAKE FORM

Welcome to CNY Family Care! We are pleased to serve your health care needs and those of your family. To assist our providers and staff, please complete this information to the best of your ability.

Patient Name: _____

Preferred Name: _____

Child's Address: _____
Street City/Town State Zip code

Home #: (____) _____ **Parent #:** (____) _____ **Child's #**: ❑NA (____) _____

Cell Phone Carrier: _____

Parent/Guardian Email: _____

Child's Email: _____

Date of Birth: ____/_____/____ **Child's SS#**: _____- _____ - _____ **Race**: _____ **Language**: _____
Ethnicity: ❑ Non-Hispanic/Latino ❑Hispanic/Latino
Child's Sex at Birth: ❑Male ❑Female
Child's Current Sex: ❑Male ❑Female
Gender Identification *(for adolescents only)*: ❑Male ❑Female ❑Transgender Male ❑Transgender Female ❑Non-binary

Pharmacy: _____
Street City/Town State Zip code

Secondary Pharmacy: ❑NA _____
Street City/Town State Zip code

Mail Order Pharmacy: ❑NA _____
Street City/Town State Zip code

PARENT #1 INFORMATION

Parent #1 Name: _____ **DOB**: ___/____/_____ **Gender**: ❑M ❑F
❑Mother ❑Father ❑Adoptive Mother ❑Adoptive Father

Address/Phone # if different from child's above: _____

Parent # 1 Cell: (____) _____

Employer: _____

Employer Address _____
Street City/Town State Zip code

Employer's Phone #: (_____) _____

Patient Name: _____ **Date of Birth**: _____/_____/_____

PARENT #2 INFORMATION

Parent #2 Name: _____ **DOB**: ___/____/_____ **Gender**: ❑M ❑F
❑Mother ❑Father ❑Adoptive Mother ❑Adoptive Father

Address/Phone # if different from child's above: _____

Parent # 1 Cell: (____) _____

Employer: _____

Employer Address _____
Street City/Town State Zip code

HIPAA CONTACT INFORMATION

Emergency Contact: _____ (____) _____
(Person not living with child) Name Relationship Phone number

Emergency Contact's Address: _____
Street City/Town State Zip code

LEGAL GUARDIAN INFORMATION

If the parent(s) are not the child's Legal Guardian(s), please list below who is the Legal Guardian(s) for this child:

_____ (___)_____
Name Relationship Address (If different then child's address listed above) Phone number

_____ (___)_____
Name Relationship Address (If different then child's address listed above) Phone number

_____ (___)_____
Name Relationship Address (If different then child's address listed above) Phone number

Please explain any particular circumstances regarding custody and parties involved in medical decision making:

Patient Name: _____ **Date of Birth**: _____/_____/_____

PRIMARY INSURANCE INFORMATION

Person Responsible for the bill (Guarantor): _____
Name Relationship

Primary Insurance: _____ **Policy Holder Name**: _____

Policy/ ID #: _____ **Policy Holder DOB**: _____/_____/_____

Patients Relationship to Policy Holder: ❑ Self ❑ Child ❑ Other: _____

SECONDARY INSURANCE INFORMATION

Person Responsible for the bill (Guarantor): _____
Name Relationship

Primary Insurance: _____ **Policy Holder Name**: _____

Policy/ ID #: _____ **Policy Holder DOB**: _____/_____/_____

Patients Relationship to Policy Holder: ❑ Self ❑ Child ❑ Other: _____

Who completed this form? ❑Mother ❑Father ❑Adoptive Mother ❑Adoptive Father ❑Child/ Self ❑Other

Name (if other): _____

The above information is accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance not covered by insurance. I also authorize CNY Family Care or the insurance company to release any information required to process claims.

Patient/Guardian Name: _____

Patient/Guardian signature: _____ **Date:** _____/_____/_____

Patient Name: _____ **Date of Birth**: _____/_____/_____

IMMUNIZATION HISTORY

IMPORTANT: We ask that you attach a copy of your child's immunization record and return it with this intake form.

ALLERGIES

Does the child have any food allergies? ❑ No ❑ Yes→ ❑Cow's Milk ❑Eggs ❑Tree Nuts ❑Peanuts ❑Shellfish ❑Wheat ❑Soy ❑Other food allergies: _____

Has the child had an allergic reaction to:

Iodine or X-ray contrast dye	❑ No ❑ Yes	Bee or wasp stings	❑ No ❑ Yes
Latex	❑ No ❑ Yes	Adhesive tape	❑ No ❑ Yes

Has the child had hives, skin rash, breathing problems, or other allergic reactions to medications?
❑ No ❑ Yes→ Describe below:

Name of Medication	Describe Allergic Reaction

MEDICATIONS

Is the child currently taking prescription or non-prescription medications, including vitamins, nutritional supplements, birth control, pain relievers, diuretics, laxatives, and herbal remedies?
❑ No ❑ Yes→ List medications below:

Name of Medication	Dose	How Often Taken	Reason for Use

HEALTH MAINTENANCE HISTORY

Has the child/ patient received the following HEALTH MAINTENANCE? If yes, indicate the date of the last exam/ test and who performed it.

Dental Exam	❑ Unknown	❑ Yes	❑ No	Date: _____	Where: _____
Eye Exam	❑ Unknown	❑ Yes	❑ No	Date: _____	Where: _____
Routine Physical Exam	❑ Unknown	❑ Yes	❑ No	Date: _____	Where: _____
Lead Test	❑ Unknown	❑ Yes	❑ No	Date: _____	Where: _____

CHILDHOOD ILLNESS

Indicate if the child has had:
Any serious childhood illnesses? ❑ None ❑ Chickenpox ❑ Measles ❑ Meningitis ❑ Mumps ❑ Pertussis ❑ Poliomyelitis ❑ Rheumatic Fever ❑ Rubella ❑ Other: _____

Patient Name: _____ **Date of Birth**: _____/_____/_____

MEDICAL PROBLEMS REVIEW

Has the child had any of the following?	NO	YES	Describe the problem when appropriate.
ADHD/ ADD _____	❑	❑	_____
Allergies_____	❑	❑	_____
Ear Infections (recurrent) _____	❑	❑	_____
Developmental Problems _____	❑	❑	_____
Diabetes _____	❑	❑	_____
Joint Disorder _____	❑	❑	_____
Mental Illness _____	❑	❑	_____
Mononucleosis _____	❑	❑	_____
Sexually transmitted disease(s) _____	❑	❑	_____
Treatment for alcohol and/or drug use _____	❑	❑	_____

Indicate whether the child ever had a <u>medical problem and/or surgery related</u> to each following by placing a check (√) in the appropriate boxes. If they had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

❑ Poliomyelitis ❑ Rheumatic Fever ❑ Rubella ❑ Other: _____	No Problem	Medical Problem	Had Surgery	Year(s)	Describe
Eyes	❑	❑	❑		
Ears, nose, sinuses, tonsils (tubes)	❑	❑	❑		
Thyroid or parathyroid glands	❑	❑	❑		
Coronary (heart), heart arteries, heart valves, heart rhythm	❑	❑	❑		
Arteries (aorta, arteries to head, arms, legs)	❑	❑	❑		
Veins, blood clots in the veins	❑	❑	❑		
Lungs (asthma)	❑	❑	❑		
Esophagus or stomach (ulcer, reflux)	❑	❑	❑		
Bowel (small & large intestine)	❑	❑	❑		
Appendix, Intestinal Disorder)	❑	❑	❑		
Liver or gall bladder (including Hepatitis)	❑	❑	❑		
Hernia	❑	❑	❑		
Kidneys or bladder (urinary disorder)	❑	❑	❑		
Bones, joints, muscles, back neck, spine	❑	❑	❑		
Brain (seizure disorder, Meningitis)	❑	❑	❑		
Skin (eczema, acne)	❑	❑	❑		
FEMALES: uterus, tubes, ovaries	❑	❑	❑		
MALE: prostate, penis, testes, vasectomy	❑	❑	❑		
Other: (please describe)					

Has the child had Anesthesia Complication(s)? ❑ No ❑ Yes→ ❑ Malignant Hyperthermia ❑ Seizure

❑ Arrhythmia ❑ Nausea ❑ Vomiting ❑ Other_____

Patient Name: _____ **Date of Birth**: _____/_____/_____

Child's Former Primary Care Provider: _____
Provider Name Practice Name

_____ (____) _____
Street City/Town State Zip code Phone

HOSPITALIZATIONS

Has the child ever been hospitalized? ❑ No ❑ Yes→ Describe below

Year	Reason	Facility	(Name and address if out of local area)

SERIOUS ACCIDENTS OR INJURIES

Serious Accidents/ Injuries? ❑ None ❑ Auto Accident ❑ Burn Injury ❑ Concussion ❑ Electrocution Injury ❑ Fracture ❑ Head Injury ❑ Laceration (Deep Cuts) ❑ Penetrating Wound (Stabbing) ❑ Sports-Related Injury ❑ Sprain ❑ Strain ❑ Other: _____

Please list below any specialists the child sees OR has seen, and their contact information (phone number, address):

_____

_____

_____

ASSISTIVE DEVICES

Please indicate if the child currently requires any assistive devices.

Brace(s): ❑ Knee ❑Neck ❑Wrist ❑ Back

Crutches: ❑ Axillary Crutches (armpit) ❑ Forearm Crutches

Hearing Aid: ❑ Bilateral ❑ Left ❑ Right

Wheelchair: ❑ Manual ❑ Electric

Contacts: ❑ Soft contacts ❑ Hard contacts

Glasses: ❑ Glasses ❑ Bifocals ❑ Trifocals

Wears Corrective Shoes: ❑ Left Foot ❑ Right Foot ❑ Bilateral Feet

❑ NONE (Child does not require any assistive devices)

For girls only) OBSTETRICS/ GYNECOLOGIC HISTORY

Has she started menstrual periods? ❑ No ❑ Yes→ **Age of first menstrual period:** _____

Last Menstrual Period (Approx.) _____

Period Frequency: ❑ Regular (once a month) ❑ Irregular

Is she sexually active? ❑ No ❑ Yes→ **Current Contraceptive Method(s):** _____

BIRTH HISTORY

Was the child born at term? ❑ Yes ❑ No ❑ Early ❑ Late **If early or late, how many weeks gestation? _____**

Delivery Type: ❑ Breech ❑C-Section (Emergency) ❑C-Section (Scheduled) ❑Vaginal ❑ Vaginal w/ Forceps Assist ❑ Vaginal w/ Vacuum Assist

Birth Length: _____ **Birth Weight**: _____ **Hospital Discharge Weight**: _____

Patient Name: _____ **Date of Birth**: _____/_____/_____

Child's Blood Type: ❑ A ❑ Positive ❑ Negative
❑ B ❑ Positive ❑ Negative
❑ AB ❑ Positive ❑ Negative
❑ O ❑ Positive ❑ Negative

Newborn Hearing Test: ❑ Pass ❑ Failed
Jaundice: ❑ Yes ❑ No
HepB: ❑ Immunized ❑ Not Immunized

Mother Pregnancy Problems/Complications/Delivery: ❑ No ❑ Yes,→ Describe: _____

FAMILY HISTORY MEDICAL ISSUES

Is the child adopted?

❑ **Yes,** → If known, complete the following information below about the child's **blood** relatives. Exclude adoptive parents and siblings

❑ **No** → Complete the following information about the child's **blood** relatives. Exclude adoptive parents and siblings.

Place a checkmark (√) in the appropriate boxes to identify all illnesses/conditions **you know have occurred** in the child's **blood relatives**. Check "NONE" if you are not aware of any relative having the illness/condition. Describe the illness or condition.

Illness/Condition	Child's Family Members									Describe
	Father	Mother	Brothers	Sisters	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	None	
Immune Problems, HIV, AIDS										
Alcoholism										
Addiction - Drugs										
Anemia										
Arthritis (childhood) (JRA)										
Birth Defects										
Bleeding Disorder or Clotting Disorder										
Crohn's or ulcerative colitis										
Developmental Delay										
Diabetes										
Epilepsy or Convulsions										
Heart Disease (before 50 years old)										
High Blood Pressure (before age 50)										
Kidney Disease										
Liver Disease										
Mental Illness										
Intellectual Disability (Mental Retardation)										
Thyroid Disease										

HOME ENVIRONMENT

What is the child's current living arrangement?

❑Apartment ❑Car ❑Friend's Home ❑Relative's Home ❑Group Home ❑House ❑Trailer
❑Homeless-living on the street ❑Homeless-staying in a shelter

Patient Name: _____ **Date of Birth**: _____/_____/_____

Please list all those living in the child's home:

Name	Relationship to Child	Birthdate	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pets in the child's home? ❑ No ❑ Yes ❑ Dogs (#: ___) ❑Cats (#: ___) ❑Other Type: _____ (#: ____)

Is the child exposed to tobacco or marijuana smoke in the home? ❑Yes ❑No

Are their guns in the child's home? ❑Prefer Not to Answer ❑No ❑Yes, locked up ❑Yes, not locked up

Child is currently attending: ❑Daycare ❑Elementary school (grade: _____) ❑High School (grade: _____)
❑Home school (grade: _____) ❑None (child stays home with parent/ guardian)

BARRIERS TO CARE

Parent/ Guardian – please indicate if your child has any learning barriers:

❑Cognitive ability impaired ❑Deafness-complete ❑Hearing impaired ❑Impaired memory ❑Unable to read
❑Unable to understand when he/she reads ❑Vision Impaired _____
❑**None Identified** – The child does not have any barriers to learning

❑ Other: _____

Parent/ Guardian – please indicate if your child is receiving any community services?

❑Head Start Program ❑Day Service Program ❑Home Care ❑Occupational Therapy ❑Physical Therapy
❑**No** - Child does not receive any services

❑ Other: _____

Parent/ Guardian – please indicate if your child is currently experiencing any abuse?

❑No ❑Yes-Bullying in school ❑Yes-Domestic Violence ❑Yes-Emotional abuse ❑Yes-Physical abuse
❑Yes-Sexually abused

Parent/ Guardian – please indicate if your child has been abused in the past?

❑No ❑Yes-Bullied in school ❑Yes-Domestic Violence ❑Yes-Emotionally abused ❑Yes-Physically abused
❑Yes-Sexually abused

Is the child on any special diet?
❑No, Generally Healthy, Well Balanced ❑Yes, specify_____

Does your child have a job? ❑Yes ❑No

Occupation? _____
_____

Patient Name: _____ **Date of Birth**: _____/_____/_____

Can your child perform any of the below activities of daily living?

	Ambulating	Bathing	Cooking	Cleaning	Dressing	Grooming	Laundry	Meds	Money	Shopping	Standing	Telephone	Toileting
Dependent													
Independent													
Requires Assistance													

Personal Habits:

Does the child drink any Caffeine? ❑No ❑Yes

If yes, what type of caffeine? ❑ Energy Drinks (how many per day) _____
❑ Coffee (how many cups per day) _____
❑ Chocolate (how much per day) _____
❑ Iced Tea (how much per day) _____

Does the child play any sports? ❑No ❑Yes: ❑ Rarely ❑Regularly ❑ Sporadically ❑In Season

If yes, which sport/'s does the child play? _____ Frequency _____

Does the child Drive? ❑No ❑Yes

Driver's License: ❑No ❑Yes How Long? _____

Learner's Permit: ❑No ❑Yes How Long? _____

When the child is driving/passenger do they wear their seatbelt? ❑Always ❑Sometimes ❑Never

Does the child ride a bike? ❑No ❑Yes

When riding their bike, does the child wear a helmet? ❑Always ❑Sometimes ❑Never ❑N/A

I have completed this Pediatric Intake Form to the best of my ability –

Patient/Guardian Name: _____

Patient/Guardian signature: _____ **Date:** _____/_____/_____

Routine Visit Schedule
Revised 3/10/2020.

3-5 DAYS OLD (24-48 hours after hospital discharge): WEIGHT/JAUNDICE CHECK

(**2 WEEK VISIT**: NOT ROUTINE – FOR SICK NEWBORN CHECKUPS ONLY)

2 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS, POSTNATAL SCREEN

4 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS, POSTNATAL SCREEN

6 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS

9 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, VISION CHECK

12 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, HEMOGLOBIN/LEAD LEVEL, IMMUNIZATIONS

15 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS

18 MONTH VISIT: GROWTH & DEVELOPMENT CHECK, IMMUNIZATIONS, HEMOGLOBIN LEVEL IF NECESSARY

2 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN TB, HEMOGLOBIN/LEAD LEVEL, VISION CHECK

3-4 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, HEARING SCREEN, LEAD SCREEN AS NEEDED

5 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, IMMUNIZATIONS, VISION CHECK, LEAD SCREEN AS NEEDED

6-10 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, MAKE UP IMMUNIZATIONS IF NECESSARY, LEAD SCREEN AS NEEDED

11 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, IMMUNIZATIONS, LIPID PANEL

12-18 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, CARDIAC SCREEN, MAKEUP IMMUNIZATIONS AS NECESSARY, ADOLESCENT SCREENS

19-21 YEARS: GROWTH & DEVELOPMENT CHECK, SCREEN FOR TB, VISION CHECK, CARDIAC SCREEN, MAKE UP IMMUNIZATIONS AS NECESSARY, ADOLESCENT SCREENS, TRANSFER TO ADULT PHYSICIAN