# CNY FAMILY CARE PEDIATRIC PATIENT INTAKE FORM

THIS FORM MUST BE COMPLETED AND SENT BACK TO THE OFFICE WITHIN 30 DAYS

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

**PATIENT INFORMATION:**

**Name**: _____ **DOB**: _____ **Preferred Name**: _____

**Child's Address**: _____

**Child's SS#**: _____ **Race**: _____ **Primary Language**: _____

**Ethnicity**: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Would prefer not to say ☐ Unknown

**Child's Sex at Birth**: ☐ Male ☐ Female **Child's Current Sex**: ☐ Male ☐ Female

**Gender Identification**: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Nonbinary

☐ Other (please specify): _____

**Primary Pharmacy**: _____ **Pharmacy Address**: _____

**Secondary Pharmacy**: _____ **Pharmacy Address**: _____

**Mail Order Pharmacy**: _____

**INSURANCE INFORMATION:**

**Name of Guarantor/Person responsible for medical bills**: _____ **Relationship**: _____

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

**Policy ID Number**: _____ **Policy Holder's DOB** _____

**Patient's relationship to Policy Holder**: ☐Self ☐ Child ☐ Other: _____

**Secondary Insurance (if applicable)**: _____ Policy Holder's Name: _____

**Policy ID Number**: _____ **Policy Holder's DOB** _____

**Patient's relationship to Policy Holder**: ☐ Self ☐ Child ☐ Other: _____

The above information is accurate to the best of my knowledge.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to CNY Family Care, LLP. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health / medical plan to issue payments directly to CNY Family Care, LLP for medical services rendered to myself and / or my dependents. I understand that I am personally financially responsible for any amounts not covered by insurance. This assignment shall remain in place until I revoke it.

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

**Patient/Guardian Name**: _____

**Who completed this form?**

☐ Mother ☐ Father ☐ Adoptive Mother ☐ Adoptive Father ☐ Child/Self ☐ Other: _____

**PARENT #1 INFORMATION:**

**Parent Name**: _____ **DOB**: _____ **Gender**: ☐ M ☐ F

**Relationship**: ☐ Mother ☐ Father ☐ Adoptive Mother ☐ Adoptive Father ☐ Other: _____

**Address** (if different from child's): _____

**Cell Phone**: _____ **Home Phone**: _____ **Work Phone**: _____

**Cell Phone Carrier** (Verizon, T-Mobile): _____ **Work Phone**: _____

**Email address**: _____

**PARENT #2 INFORMATION:**

**Parent Name**: _____ **DOB**: _____ **Gender**: ☐ M ☐ F

**Relationship**: ☐ Mother ☐ Father ☐ Adoptive Mother ☐ Adoptive Father ☐ Other: _____

**Address** (if different from child's): _____

**Cell Phone**: _____ **Home Phone**: _____ **Work Phone**: _____

**Cell Phone Carrier** (Verizon, T-Mobile): _____ **Work Phone**: _____

**Email address**: _____

**APPOINTMENT REMINDER VIA TEXT MESSAGE OR PHONE CALL**

Please be aware, CNY Family Care can only send appointment reminders to one designated number. Our preferred method is text which requires a cell phone. Please indicate below the specific number you would like us to send appointment reminders to.

**Phone Number**: _____ **Cell Phone Carrier (Verizon, T-Mobile, etc.)** : _____

☐ Home Phone ☐ Cell Phone

**HIPAA CONTACT INFORMATION**: Emergency Contact (person not living with child)

**Name**: _____ **Relationship to child**: _____ **Phone Number**: _____

**Name**: _____ **Relationship to child**: _____ **Phone Number**: _____

**LEGAL GUARDIAN INFORMATION** - If the parent(s) are not the child's Legal Guardian(s), please list below who is the legal guardian for this child

**Name**: _____ **Relationship to child**: _____ **Phone Number**: _____ **Address**:

_____

**Please explain any particular circumstances regarding custody and parties involved in medical decision making and send this packet back with any relevant court/legal documentation:**

_____

_____

_____

_____

## PEDIATRIC MEDICAL, FAMILY, and SOCIAL HISTORY

We ask that you attach a copy of your child's immunization record and **return it with this intake form**.
Please bring a copy of your child's current medications to their **first appointment.**

**ALLERGIES**

**Does your child have any food allergies**?

☐ No ☐ Yes → ☐ Cow's Milk ☐ Eggs ☐ Tree Nuts ☐ Nuts ☐ Shellfish ☐ Wheat ☐ Soy

☐ Other food allergies: _____

**Has your child had an allergic reaction to**:

☐ Iodine or X-Ray Contrast Dye
☐ Latex
☐ Bee or Wasp Stings
☐ Adhesive Tape

**Has your child had hives, skin rash, breathing problems, or other allergic reactions to medications**?

***NAME OF MEDICATION*** ***DESCRIBE ALLERGIC REACTION***

_____

_____

**Has your child experienced any of the following serious childhood illnesses?**

☐ Chickenpox ☐ Measles ☐ Meningitis ☐ Mumps ☐ Pertussis ☐ Poliomyelitis ☐ Rheumatic Fever ☐ Rubella

☐ None ☐ Other: _____

**Has your child experienced any of the following accidents/injuries?**

☐ None ☐ Auto Accident ☐ Burn Injury ☐ Concussion ☐ Fracture ☐ Head Injury
☐ Laceration (Deep Cuts) ☐ Penetrating Wound (Stabbing) ☐ Sports Related Injury ☐ Sprain ☐Strain

☐ Other: _____

**List any medical problems your child has and the date of diagnosis if known**:

_____

_____

**List any surgeries your child has had with approximate date of surgeries if known**:

_____

_____

**Has your child had any anesthesia complications?** ☐ No ☐ Yes → ☐ Malignant Hyperthermia ☐ Seizure

☐ Arrythmia ☐ Nausea ☐ Vomiting ☐ Other: _____

**Has your child ever been hospitalized?** ☐ No ☐ Yes → Describe Below:

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

_____

_____

**Child's Former Primary Care Physician**:_____ **Practice Name**: _____

**Date of Last Well Child Check/Physical**: _____

**Please list below any specialists your child currently sees**:

*Specialty* *Doctor Name* *Practice Name* *Address*

_____

_____

_____

**Please indicate below if your child currently uses/requires any assistive devices**

☐ None (child does not require any assistive devices)
☐ Life Line/Medical Alert Device ☐ Automated Medication Dispenser
☐ Built Up or Special Utensils

Sleep Apnea Device: ☐ CPAP ☐ APAP ☐ BIPAP ☐ MAD ☐ Inspire Implant

Brace(s): ☐ Back ☐ Neck ☐ Left Shoulder ☐ Right Shoulder
☐ Left Elbow ☐ Right Elbow ☐ Left Knee ☐ Right Knee ☐ Left Wrist ☐ Right Wrist

Cane: ☐ Quad Left Hand ☐ Quad Right Hand ☐ Standard Left Hand ☐ Standard Right Hand

Chair: ☐ Commode ☐ Power Lift Recliner ☐ Shower Chair ☐ Stair Lift Chair

Contacts: ☐ Soft Contacts ☐ Hard Contacts

Corrective Shoes: ☐ Left Foot ☐ Right Foot ☐ Bilateral (both feet)

Crutches: ☐ Auxiliary Crutches (armpit) ☐ Forearm Crutches

Dentures: ☐ Partial-Lower ☐ Partial-Upper ☐ Partial-Lower and Upper
☐ Complete-Lower ☐ Complete-Upper ☐ Complete-Lower and Upper

Glasses: ☐ Glasses ☐ Bifocals ☐Trifocals

Hearing Aid: ☐ Bilateral (both sides) ☐Left ☐Right

Bed: ☐ Hospital Bed ☐ Bariatric Hospital Bed

Walker: ☐ Rolling (4 wheels) ☐ Rolling (4 wheels) Platform Attached ☐ Standard (2 wheels)
Wheelchair: ☐ Manual ☐ Electric ☐ Bariatric Manual ☐ Bariatric Electric

☐ Other- please specify: _____

**Was your child born at term?** ☐ Yes ☐ No→ How many weeks gestation? _____

**Delivery Type**: ☐Vaginal ☐ Vaginal w/ Forceps Assist ☐ Vaginal w/ Vacuum Assist

☐ C-Section (Scheduled) ☐ C-Section (Emergency) ☐ Breech

**Birth Length**: _____ **Birth Weight**: _____

**Were there any problems during pregnancy or birth complications**: ☐ No ☐ Yes, please describe below:

_____

_____

**For Female Patients Only:**

**Has the patient started menstrual periods?** ☐ No ☐ Yes → Age of first menstrual period? _____

**Is the patient sexually active?** ☐ No ☐ Yes → Current Contraceptive Method(s): _____

## FAMILY MEDICAL HISTORY:

-If your child is adopted please complete the following information below about the child's blood relatives. If unknown medical history, please write "unknown".
-If blood relative is deceased, please write "deceased" and list cause of death if known.

**Mother's Medical History (significant medical problems)**: _____

_____

**Father's Medical History (significant medical problems):** _____

_____

**Does your child have any siblings**? ☐ No ☐ Yes→ # of Brothers? _____ # of Sisters? _____

**Sibling's Medical History** (please list name of sibling and any significant medical problems):

_____

_____

_____

## SOCIAL HISTORY:

**What is your child's current living arrangement:** ☐ House ☐ Apartment ☐ Trailer ☐ Relatives House ☐ Friend's House

☐ Group Home ☐ Car ☐ Homeless-living on street ☐ Homeless-staying in shelter

**Please list all the people that your child lives with (Name and Relationship to Child):**

_____

_____

**My child is currently attending:**

☐ Daycare ☐ Elementary school (grade: _____) ☐High School (grade: _____) ☐ Home school (grade: _____)

☐ None (child stays home with parent/ guardian)

**Is your child currently following a special diet? (<u>check all that apply</u>):**

☐ No diet restrictions
☐ Cardiac diet
☐ Diabetic diet
☐ Gluten-free diet
☐ High fiber diet
☐ Lactose-free diet
☐ Low-calorie diet
☐ Low-carbohydrate diet
☐ Low cholesterol diet
☐ Low-fat diet
☐ Low-sodium diet
☐ PKU diet
☐ Protein-Sparing Modified Fast diet (high protein, very low-calorie, minimal carbohydrates and fats)
☐ Renal diet
☐ Vegan diet
☐ Vegetarian diet

**Does your child have a job**? ☐ No ☐ Yes → Occupation: _____ ☐Part Time ☐Full Time

## <u>BARRIERS TO CARE</u>

**Social Determinants** Is your child currently facing any challenges or difficulties in their life that may impact their health or well-being? (<u>check all that apply</u>):

☐ Difficulty accessing transportation
☐ Difficulty accessing transportation
☐ Homebound (leaving home very difficult)
☐ Homelessness
☐ Limited access to nutritious food
☐ Unsafe quality housing
☐ None of the above

**Social Functioning** Is your child currently facing any challenges or difficulties that may impact their social life and functioning? (<u>check all that apply</u>):

☐ Absence of social activities/ social engagement
☐ Anxiety/ Depression
☐ Declining Health/Cognition/Memory
☐ Isolation
☐ Lack of family network
☐ Lack of a friend network
☐ None of the above

**Treatment at Our Office** Are you or your child currently facing any challenges or difficulties in their life that might affect their ability to receive care <u>at CNY Family Care?</u> (<u>check all that apply</u>):

☐ Family responsibilities
☐ Financial hardship
☐ Geographic location/ long distance from home to office
☐ Insurance status
☐ Language
☐ Transportation
☐ Work Hours
☐ None of the above

**Is your child currently experiencing any of the following issues that may affect their ability to learn and understand medical advice? (check all that apply):**

☐ Autism
☐ Cannot understand information
☐ Cognitive ability impaired
☐ Deafness (complete)
☐ Dyslexia
☐ Hearing Impaired
☐ Impaired memory
☐ Intellectually Disabled
☐ Legally blind
☐ Vision impaired
☐ Unable to read
☐ Unable to understand what they read
☐ None of the abov

**Is your child currently facing any of the following communication barriers? (check all that apply):**

☐ Deafness (complete)
☐ Hearing Impaired
☐ Legally blind
☐ Need a translator at medical appointments
☐ Needs an American Sign Language (ASL) interpreter at medical appointments
☐ Nonverbal (does not speak)
☐ Primary language is not English
☐ None of the above

**Is your child currently receiving any community services?**

☐ Head Start Program ☐ Day Service Program ☐ Home Care ☐ Occupational Therapy ☐ Physical Therapy

☐ Speech Therapy ☐ None of the above ☐ Other: _____

**Please indicate if your child is currently experiencing any abuse?**

☐ Not currently experiencing abuse ☐ Bullying in School ☐ Emotional abuse ☐ Physical Abuse ☐Sexual Abuse

**Please indicate if your child has been abused in the past?**

☐ Not currently experiencing abuse ☐ Bullied in School ☐ Emotionally abused ☐ Physically Abused ☐ Sexually Abused

## PERSONAL HABITS

**Is your child currently using caffeine daily (this includes coffee, energy drinks, hot tea, iced tea, soda)?**

☐ Does not consume caffeine

☐ Currently consume caffeine, but only occasionally

☐ Yes → Specify the type of caffeine product(s) they consume daily and the number of times they drink them per day

(with mg of caffeine if known): _____

## For Adolescent Patients Age 13-17 Only

**Does your child smoke a vape or an e-cigarette?**

☐ No

☐ Yes, Vape → # Times Per Day: _____ Times Per Week: _____ Year you started: _____

☐ Yes, E-cigarette→ # Times Per Day: _____ Times Per Week: _____ Year you started: _____

**Does your child smoke tobacco products (this includes cigarettes, cigars, and tobacco pipes)?**

☐ Never smoked tobacco products
☐ Occasionally smokes tobacco products
☐ Smokes tobacco products regularly

**What type of tobacco product does your child currently smoke, and how often do they smoke?**

☐ N/A – Does not smoke tobacco

☐ Cigarette # Cigarettes Per Day: _____ # Packs Per Day: _____

☐ Cigar # Cigars Per Day: _____ # Cigars Per Week: _____

☐ Pipe # Pipe Per Day: _____ # Pipe Per Week: _____

What year did they start smoking tobacco? _____ ☐ N/A – Does not smoke tobacco

**Is your child a former tobacco smoker?**

☐ No

☐ Yes → Tobacco Type: _____ Amount/ Frequency: _____

What year did they QUIT smoking? _____ What year did they start smoking tobacco? _____

**Does your child currently use chewing tobacco?**

☐ No

☐ Yes → # Times Per Day: _____ # Times Per Week: _____ Year they started chewing: _____

**Does your child currently use ZYN nicotine pouches (tobacco-free)?**

☐ No

☐ Yes → # Times Per Day: _____ #Times Per Week: _____ Year you started: _____

**Does your child currently use cannabis (this includes marijuana, THC, weed, pot, ganja, hash)?**

☐ Never used cannabis

☐ Occasionally uses cannabis

☐ Uses cannabis regularly → Specify how your child uses cannabis (ex: smoking, vaping, dabs, edibles/gummies, capsules, tinctures, sublingual strips) and how often they use it:

_____

_____

**Does your child currently drink alcohol (this includes beer, wine, and liquor)?**

☐ Never used alcohol

☐ Occasionally drinks alcohol

☐ Drinks alcohol regularly → Specify how many drinks per day? _____

Specify how many drinks per week? _____

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

**Patient/Guardian Name:** _____

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