Orthopedics for Kids

New Patient History

Patient's Name:_____Date of Birth:_____
Primary Care Physician:_____
Reason for visit: _____
_____
Drug Allergies (Circle or List): NONE /_____
Child's Birth History (Check One): Biologic_____ Adopted_____Step Child_____Other_____
Any complications at delivery (Circle or List): NONE/_____
_____
Child's Prior Surgeries & Hospitalizations (Circle or List): NONE/_____
_____
_____
Child's Current Medications (Circle or List): NONE /
1. 3. 5.
2. 4. 6.

Has your child experienced any of the following:

Y N Eye Problems/Eyeglasses	Y N Recent Fever greater than 102	Y N Diabetes
Y N Migraine Headaches	Y N Fatigue	Y N Growth Hormone Rx
Y N Epilepsy/Seizures	Y N Rash	Y N Hypo/Hyperthyroidism
Y N Balance/Coordination Problems	Y N Swollen Joints	Y N Weight change
Y N Developmental Delay	Y N Diarrhea/Constipation	Y N Tuberculosis
Y N Speech/Feeding Difficulties	Y N Reflux	Y N BiPap/Oxygen
Y N Numbness/Tingling	Y N Incontinence/CIC	Y N Asthma/BPD
Y N Toe Walking	Y N Blood Disorder/Sickle Cell/Anemia	Y N Pneumonia
Y N Latex Allergy	Y N HIV	Y N Cystic Fibrosis
Y N Hearing Loss	Y N Congenital Heart Disease	Y N Pain _____
Y N Anxiety/Depression	Y N Heart Murmurs	Y N Menstrual Cycle:
Y N ADD/ADHD		Regular Irregular

Comments or Additional History:_____
_____
_____
_____

Please list any other specialists or therapists that currently care for your child:

_____
_____

Family History:

Y N Scoliosis	Y N Rheumatoid Arthritis	Y N Nerve disorders
Y N Club Feet	Y N Lupus	Y N Neurofibromatosis
Y N Osteoarthritis	Y N Dislocated hip	Y N Muscle disease
Y N High Blood Pressure	Y N Heart Disease	

Comments or Additional History:_____
_____

Parent's Age _____years Health: Good/Fair/Deceased/Unknown
Parent's Age _____years Health: Good/Fair/Deceased/Unknown
Brothers/Sisters of the patient
Male/Female age_____years Health: Good/Fair/Deceased/Unknown
Male/Female age_____years Health: Good/Fair/Deceased/Unknown
Male/Female age_____years Health: Good/Fair/Deceased/Unknown
Male/Female age_____years Health: Good/Fair/Deceased/Unknown

Social History:
Child lives in home with: ____Parents_____ Other: _____
Does your child smoke? Y N use alcohol? Y N Does anyone in the home smoke? Y N
School_____Grade_____
Signature:_____Relationship to Patient:_____Today's Date:____
Reviewed by:_____, MD Date:_____

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Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information

_____ _____
(Childôs Name) (Birth Date)

_____ _____
(Childôs Social Security Number) (Todayôs Date)

By providing this authorization I understand that the authorization is **voluntary** and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Orthopedics for Kids, P.C. in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise. This form does not authorize anyone other than a parent or legal guardian to consent for treatment by Orthopedics for Kids.

I hereby authorize Orthopedics for Kids, P.C. to use, disclose or obtain health information from the parties I list below, and that any person not listed below will not have access to information regarding the patient other than my childôs pediatrician and me.

_____ Name	_____ Relationship to patient
_____ Name	_____ Relationship to patient
_____ Name	_____ Relationship to patient
_____ Name	_____ Relationship to patient

PLEASE NOTE THAT CHECKING ANY BOX BELOW MAY RESULT IN THE STAFF OF ORTHOPEDICS FOR KIDS, P.C. LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE AT THE NUMBER REQUESTED BY YOU.

Yes	**No**	
☐	☐	The physicians and staff of Orthopedics for Kids **may confirm appointments to my answering machine** at the number provided on my Patient Information Sheet.
☐	☐	The physicians and staff of Orthopedics for Kids **may leave lab results or results of other diagnostic studies (e.g., MRI, CT, bone scan, etc.) on my answering machine.**
☐	☐	The physicians and staff **may release information to my pharmacy without prior authorization in order to allow call-in of a prescription.**

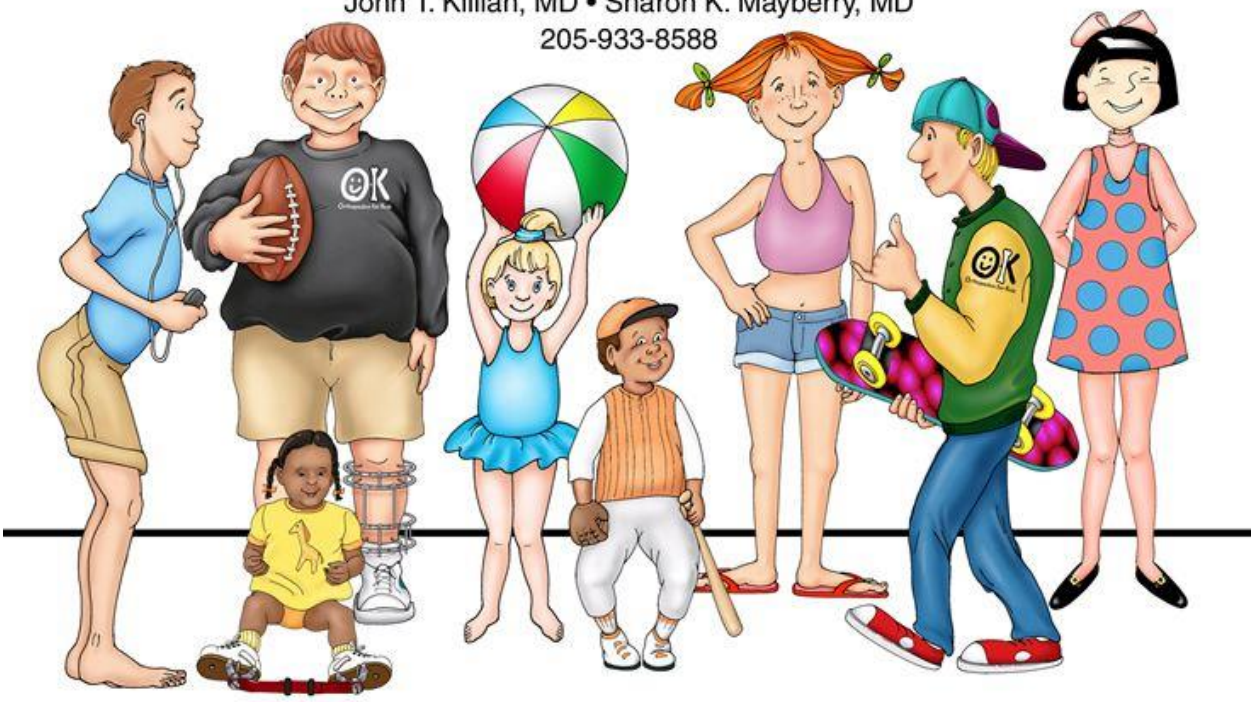
Special Instructions: _____

My signature below is acknowledgement that I have received a copy of the Privacy Notice and that I agree to the conditions stated in the notice, and acknowledges that am I the parent or legal guardian of the patient referenced above.

Parent Signature:_____ Date:_____

Orthopedics for Kids

John T. Killian, MD • Sharon K. Mayberry, MD
205-933-8588



Patient Full Name _____

Birthdate _____ Today's Date _____

E-Mail information is confidential, never sold or used for any purpose other than patient care correspondence, appointment reminders, or if unable to reach you by telephone.

Would you like to be able to correspond via E-Mail with Orthopedics for Kids?

☐ Not right now

☐ Yes, please use the following address: _____

_____ _____

Parent/Guardian Signature Date Signed

Orthopedics for Kids