LOUISVILLE PEDIATRIC SPECIALISTS, P.S.C.

New Patient Questionnaire

(To be filled out by parent or legal guardian)

Patient's Name:	AGE:	DOB:
Address:		
Parent/Guardian:	AGE:	DOB:
Address:		
Occupation:		
Parent/Guardian:	AGE:	DOB:
Address:		
Occupation		

(Please check appropriate answer)

A. PREGNANCY & BIRTH	**YES**	**NO**	**COMMENTS**
Mother's age at birth if child			
Did mother have any illness during pregnancy?			
Did she take any medications other than vitamins or iron?			
Was the baby born on time?			
What was the birth weight?			
Did the baby have trouble starting to breathe?			
Did the baby have any trouble in the hospital? (Jaundice, infections, other?)			

B. PAST MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Where has your child gone for checkups until now?			
Date of last checkup?			
Date of last dental checkup?			
Has your child had allergic reactions to any medications, food, insect bites? (If so, which ones?)			
Has your child had any reactions to immunizations? (If so, which ones?)			
Any hospitalizations other than that for birth?			
Any serious injuries?			
Any medications taken regularly? (If so, which ones?)			
Any operations?			

C. FAMILY HISTORY	**YES**	**NO**	**COMMENTS**
Are both children's parents in good health?			

Circle any disease that this child's parent, grandparents, siblings, aunts and uncles may have had:

Anemia Asthma Allergies Diabetes High Blood Pressure Heart Trouble Tuberculosis

Inherited Illness Cancer Other:_____

List age, sex, general health of brothers/sisters:

AGE	SEX	HEALTH
1.		
2.		
3.		

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4.						
D. FEEDING AND NUTRITION			**YES**	**NO**	**COMMENTS**	
Is your child's appetite usually good?						
Is it now?						
Were there severe colic or any unusual feeding problems during the first 3 months?						
Do any foods disagree with him/her?						
For the first 6 mos. Is he/she breast or bottle fed?						
If still on formula, which one do you use?						
Does he/she take vitamins?						
E. REVIEW OF SYSTEMS			**YES**	**NO**	**COMMENTS**	
Has your child had frequent ear infections?						
Any eye problems?						
Has he/she had any problems with teeth?						
Does he/she have frequent colds or sore throat?						
Is there asthma, pneumonia or recurrent cough?						
Does he/she have a heart murmur or any heart problems?						
Any type of kidney or bladder problems?						
Any problems with diarrhea or constipation?						
Have there been any convulsions or other problems with the nervous system?						
Any eczema, hives or other skin conditions?						
Has your child ever been anemic?						
Has any family member or your child been diagnosed with diabetes?						
Exposed to TB?						
Any type of orthopedic (bone) disorders?						
Please list any other medical problems:_____						
F. DEVELOPMENT/BEHAVIOR			**YES**	**NO**	**COMMENTS**	
At what age did the child sit alone?						
At what age did he/she walk alone?						
Did he/she say any words by the time he/she was 1 ½ yrs. Old?						
How does this child compare to others his or her age? (CIRCLE ONE)						
	Appropriate	**Inappropriate**				
Does he/she have trouble sleeping?						
What grade is he/she in?						
Has he/she had any trouble in school?						
Does he/she get along with other children?						
G. SAFETY/ENVIRONMENT			**YES**	**NO**	**COMMENTS**	
Do you live in a (Please circle one)						
Home	**Apartment**	**mobile home other**				
Do you know the hottest temperature of the water in your pipes?						

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Is there a working smoke alarm on each floor of the house?			
Does your child always use a car seat/seat belt when riding in the car?			
Are there any smokers in the household?			
Are there any problems with the condition of your home? (Insects, rodents, paint, etc.)			
Does your child always wear a helmet when riding his/her bike?			
H. IMMUNIZATIONS	**YES**	**NO**	**COMMENTS**
Do you have a record of immunizations?			

LOUISVILLE PEDIATRIC SPECIALISTS, P.S.C.

6801 Dixie Hwy Ste 127 Louisville, KY 40258
Phone: 502 935-5633 Fax: 502-935-5706
Email: info@loupeds.com

New Patient Questionnaire
(To be filled out by parent or legal guardian)

Consent to Treatment of a Minor When Parents/ Guardians Are Temporarily Unavailable

The undersigned parent or legal guardian of: «_____» authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person or by telephone. It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name:_____Relationship to child:_____Phone:_____

   Name:_____Relationship to child:_____Phone:_____

   Name:_____Relationship to child:_____Phone:_____

   Name:_____Relationship to child:_____Phone:_____

2. Medical Concerns:_____

3. Known allergies:
   _____

Name of Parent or Legal Guardian:_____
(Print Name)

Relationship to Child: _____

Contact Numbers:
Home: _____**Cell**: _____**Work**:_____

Address: _____City, State, Zip:_____

Signature: _____Date:_____

This Consent is effective until withdrawn in writing by the child's parent or guardian.

Louisville **Pediatric**
SPECIALISTS

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Thomas C. Hubbs, MD, FAAP
John W. Kim, MD, FAAP
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Christina S. Brown, MD, FAAP

Insurance Information	
Primary Insurance:	Employer:
Member/Subscriber ID:	Group #:
Subscriber's Name:	DOB:
Subscriber's SSN:	Relationship to Patient:
Secondary Insurance:	Employer:
Member/Subscriber ID	Group #:
Subscriber's Name:	DOB:
Subscriber's SSN:	Relationship to Patient:

Contact Preferences Circle any method at which we may contact you.	
Cell/Text	E-Mail
Postal Mail	Telephone
Is it ok to leave a message on any of the numbers you have provided? YES / NO	

Health Information Privacy	
I give the below individual(s) permission to make medical decisions regarding my child(ren) and have my child(ren) receive treatment under their supervision. I understand that it is the office policy NOT to have my child receive vaccinations or have well visits, however, without a parent or legal guardian present.	
Name:	Relation to Patient:
Name:	Relation to Patient:
Name:	Relation to Patient:
Name:	Relation to Patient:
May we discuss your child(ren)'s medical care with anyone other than the parent/guardians listed on this form? YES / NO	
If yes, whom?	Phone #:

By signing below, you are confirming that you have completed this information completely and accurately. If you would like to see a copy of our Notice of Privacy Practices please see someone at the front desk.

Signature: _____ Date: _____

Louisville Pediatric SPECIALISTS

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Family Registration

Patient Information			
Please list all children in the family for which the following information applies. Call our office any time demographic information changes.			
Name:	SSN:	DOB:	Gender:
Name:	SSN:	DOB:	Gender:
Name:	SSN:	DOB:	Gender:
Name:	SSN:	DOB:	Gender:
Address:			
City, State, Zip Code:			
Primary Language Spoken in The Home:			
Race:		Ethnicity: NON-HISPANIC HISPANIC DECLINE	
Emergency Contact (Outside of the Home):		Emergency Contact Phone:	
Pharmacy:		Pharmacy Phone:	
How did you hear about our practice?			

Parent/Guardian Information			
Name:		Name:	
Relation to Child:		Relation to Child:	
DOB:	SSN:	DOB:	SSN:
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Phone:		Phone:	
Cell Phone:		Cell Phone:	
Employer:		Employer:	
Email:		Email:	
If parents are divorced or separated or there is a custody agreement in place, please complete the following section.			
Who has primary custody?			
Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment for the child, or from obtaining information about the child's medical treatment? YES / NO			