Keeping Kids Healthy and Happy

Highlands Pediatrics

26210 Lee Highway
Abingdon, VA 24211
(276)623-8100

Pediatrician: ❑ Dr. Hudgens ❑ Dr. Johnston ❑ Dr. Myers ❑ Dr. Seeley

Child's Information:

Full Name: _____
Last *First* *Middle*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Email: _____ Language: _____

SSN: _____ Race: _____ Ethnicity: _____

Birth Date: _____ Sex: ❑ Male ❑ Female Preferred Pharmacy: _____

Insurance: _____ Policy Holder Name: _____

Insurance ID#: _____ Group #: _____

Parents OR Guardian Information:

Name: _____ SSN: _____ DOB: _____

Relationship to child: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Address (if different): _____

Name: _____ SSN: _____ DOB: _____

Relationship to child: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Address (if different): _____

Parents are: ❑ Married ❑ Separated ❑ Divorced ❑ Single Child resides with: _____

Other Children in Home:

Siblings: _____ DOB: _____ Sex: ❑M ❑F Siblings: _____ DOB: _____ Sex: ❑M ❑F

Siblings: _____ DOB: _____ Sex: ❑M ❑F Siblings: _____ DOB: _____ Sex: ❑M ❑F

Other Children in Home: _____ Other Children in Home: _____

Emergency Contact (No Parent/Guardian):

Name: _____
Relationship *Phone#:*

In addition to the Parent/Guardian, the following persons have permission to schedule appointments, bring child to Office, and leave Office with child and any medication prescriptions:

Name: _____
Relationship *Phone#:*

Name: _____
Relationship *Phone#:*

The foregoing information is true and correct as of the date signed: _____
Signature *Date*

Please notify us immediately of any changes in the information in this form.

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Child's Name: _____

Other Children in Child's Home

Name: _____ DOB: _____ Health Problems: ❑Yes ❑No

Name: _____ DOB: _____ Health Problems: ❑Yes ❑No

Name: _____ DOB: _____ Health Problems: ❑Yes ❑No

Name: _____ DOB: _____ Health Problems: ❑Yes ❑No

Child's Medical History

Where Was the Child Born? ❑ Johnston Memorial Hospital

❑ Other: _____ City: _____

How Much Did the Child Weigh at Birth? _____ lbs _____ oz. Any Birth Problems: _____

_____

Name of Prior Doctor: _____ Location: _____

Has the Child been hospitalized before? ❑Yes ❑No If so, where? _____

For What? _____

Has the Child had surgery in the past? ❑Yes ❑No If so, where? _____

For What? _____

Does the Child take regular medications? ❑Yes ❑No If so, what? _____

Is your Child allergic to any medications? ❑Yes ❑No If so, what? _____

Sleep Problems? _____

Behavior Problems? _____

Frequent Ear Infections? ❑Yes ❑No If Yes, how many in last 3 months? _____

Eye Problems? ❑Yes ❑No Teeth Problems? ❑Yes ❑No

Frequent Colds? ❑Yes ❑No Frequent Sore Throat? ❑Yes ❑No

Recurring Coughs? ❑Yes ❑No Heart Murmur? ❑Yes ❑No

Urination Problems? ❑Yes ❑No Diarrhea or Constipation? ❑Yes ❑No

Seizures? ❑Yes ❑No Skin Problems? ❑Yes ❑No

Low Blood pressure? ❑Yes ❑No

Good Appetite? ❑Yes ❑No Food Allergies? ❑Yes ❑No

Describe any Medical Problems? _____

_____

Family Medical History

Please check any **Health Problems** that any of the following relatives of your child have.

Mother: ❑Diabetes ❑Seizures ❑Cancer ❑High Blood Pressure ❑Hearing Problems ❑Heart Attack <55 ❑Asthma ❑Stroke <55 ❑Elevated Cholesterol ❑Blood Disorders ❑Other (Please List) _____

Father: ❑Diabetes ❑Seizures ❑Cancer ❑High Blood Pressure ❑Hearing Problems ❑Heart Attack <55 ❑Asthma ❑Stroke <55 ❑Elevated Cholesterol ❑Blood Disorders ❑Other (Please List) _____

Brothers: ❑Diabetes ❑Seizures ❑Cancer ❑High Blood Pressure ❑Hearing Problems ❑Heart Attack <55 ❑Asthma ❑Stroke <55 ❑Elevated Cholesterol ❑Blood Disorders ❑Other (Please List) _____

Sisters: ❑Diabetes ❑Seizures ❑Cancer ❑High Blood Pressure ❑Hearing Problems ❑Heart Attack <55 ❑Asthma ❑Stroke <55 ❑Elevated Cholesterol ❑Blood Disorders ❑Other (Please List) _____

Grandparents: ❑Diabetes ❑Seizures ❑Cancer ❑High Blood Pressure ❑Hearing Problems ❑Heart Attack <55 ❑Asthma ❑Stroke <55 ❑Elevated Cholesterol ❑Blood Disorders ❑Other (Please List) _____

Does anyone in the Child's home smoke (inside or outside)? ❑Yes ❑No

What is the source of water in the Child's home? ❑Public Water ❑Private Well ❑Other: _____

How did you hear about our office? _____

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Child's Name: _____

Insurance Release:

I give my consent for Highlands Pediatrics P.C. to supply information from my medical records to my insurance carriers, including third parties vendors or Virginia Medicaid, to allow them to make appropriate payment. I understand I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of this signature on all insurance submissions.

Signature *Date*

Immunization Informed Consent:

I agree that my child's immunization record, date of birth and address may be shared with other health care providers. I understand that this information will be used by health care providers for the care of my child and for statistical purposes only. I understand the information will be kept confidential.

Signature *Date*

Blood Testing Consent:

Since 1993 the Commonwealth of Virginia has required that if an employee at a physician's office is exposed to body fluids from a patient in a manner that might transmit Hepatitis B, Hepatitis C or Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), that the patient will be tested for these diseases. If such a test is necessary you will be informed of the blood test and you will be given the opportunity to ask any questions at that time. By signing this release you have consented to such testing and consented to the release of the test results to the health care provider who was exposed.

I have read and understood the "Blood Testing Consent"

Signature *Date*

HIPAA Privacy Notice:

I hereby acknowledge that I have received a copy of Highlands Pediatrics PC Privacy Policy Version 2.1

Signature *Relationship to Patient* *Date*

Consent to Access External Prescription History:

I authorize Highlands Pediatrics to view my child's external prescription history via the Virginia Physician Prescription Monitoring Program and/or SureScripts service for the patient listed below.

I understand that prescription history from other multiple medical providers, insurance companies, and pharmacies may be viewable by the clinical staff here, and it may include prescriptions issues in prior years.

Patient Name *Date of Birth* *Date*

Responsible Party *Signature*

Chadis Questionnaire Release:

I authorize Highlands Pediatrics to share the results of my screenings and/or questionnaires with my Obstetrician or Physician.

Name of Mother's Physician or Obstetrician *Physician Phone Number*

Signature *Mother's Name* *Date*