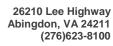


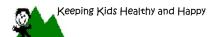
Highlands Pediatrics

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

Pe	ediatrician: 🚨 Dr.	Hudgens	Dr. Johnston	☐ Dr. Myers	☐ Dr. See	ley
		Ch	nild's Information:			
Full Name:						
Address:	Last		First		Middle	
	treet Address				Apartmei	nt/Unit #
C	ity			State	ZIP Code)
Home Phone	e:		Cell Phon	ne:		
Email:				Language:		
SSN:		Race	:	Ethnicity:		
Birth Date: _		Sex: 🗆 N	/ale ☐ Female Prefer	rred Pharmacy:		
Insurance: _			Policy Holder	Name:		
Insurance ID)#:		Group	#:		
		Parents C	R Guardian Inform	nation:		
Name:			SSN:		DOB:	
Relationship	to child:		Home Phone:			
Work Phone:			Cell Phone:			
Address (if o	lifferent):					
Name:			SSN:		DOB:	
Relationship	to child:	Home Phone:				
Work Phone	:	Cell Phone:				
Address (if c	lifferent):					
Parents are:	☐ Married ☐ Separat					
		Otne	er Children in Home	e:		Sex:□M
		DOB:	Sex:□M □F Siblings: Sex:□M		DOB:	Sex:□F
Siblings:		DOB:				
Other Childr	en in Home:		Other Childre	en in Home:		
		Emergency Co	ntact (No Parent/G	uardian):		
Name:						
				Relationship	Phone#:	
In additio	n to the Parent/Guard Office.		persons have permise ith child and any me			ing child to
Name:	,		<u> </u>			
				Relationship	Phone#:	
Name:				Relationship	Phone#:	
			K	ασιαυστιοττ ι μ	ΓΠΟΠ Ε #.	
The forego	oing information is tr	ue and correct as o	f the date signed:			
			0:		D - 1 -	

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

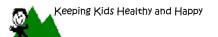




Highlands Pediatrics

PARENT OF A NEWBORN – **Welcome!**PLEASE COMPLETE THIS FORM FULLY &
GIVE TO THE RECEPTIONIST. THANK YOU.

Child's Name:						
Oth	ner 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 F	Hospital					
□ Other:	City:					
How Much Did the Child Weigh at Birth?	lbsoz. Any Birth Problems:					
Good Appetite?□Yes □No	Food Allergies?□	Yes □No				
Problems With Weight Gain?□Yes □No Colic or Other Feeding Problems?□Yes □No						
Breast Fed?□Yes □No	If Not, Which Formula?					
Describe Any Sleep Problems:						
· · · · · · · · · · · · · · · · · · ·						
Other Problems:						
	Family Madical History					
	Family Medical History					
Please check any Health Problems that any of the following relatives of your child have. Mother: Diabetes Desizures Cancer High Blood Pressure Hearing Problems Heart Attack <55 Asthma Stroke <55 Design Diabetes Disorders Other (Please List)						
Father: □Diabetes □Seizures □Cancer □High Blood Pressure □Hearing Problems □Heart Attack <55 □Asthma □Stroke <55 □Levated Cholesterol □Blood Disorders □Other (Please List)						
Brothers: ☐Diabetes ☐Seizures ☐Cancer ☐High Blood Pressure ☐Hearing Problems ☐Heart Attack <55 ☐Asthma ☐Stroke <55 ☐Levated Cholesterol ☐Blood Disorders ☐Other (Please List)						
Sisters: Diabetes Deizures 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