PEDIATRIC HISTORY FORM

SAN PEDRO PEDIATRIC MEDICAL GROUP, INC.
ANDREW P. NOVOM, M.D. - KENNETH FOLLMAR, M.D. - GRACE C. PETTERSON, M.D.
PRISCILLA S. NOVOM , M.D. - BARBARA J. SONNE, C.P.N.P., M.N.

CHILD'S FULL NAME
NOMBRE DE SU HIJO/A _____ **CHILD'S BIRTH DATE** *FECHA DE NACIMIENTO* _____

Birth weight? *Peso al nacer?* _____ **Was pregnancy normal?** *Tuvo embarazo normal?* _____

School problems?
Problemas en la escuela? _____
Special school or classes? Describe
Escuela o clase especial? Describa _____
Behavior or discipline problems? Describe
Problemas con disciplina o comportamiento? Describa. _____

Hospitalization? When? Why? Where?
Ha sido hospitalizado/a? Cuando? Porque? Donde? _____

Surgery? Describe.
Operacion/cirugia? Describa. _____

Serious injuries?
Herida seria? _____

Other serious illnesses? Describe.
Otras enfermedades serias? Describa. _____

What medications taken regularly?
Que medicinas toma regularmente? _____

Medication allergies
Alergias a medicina _____ **Type of reaction**
Typo de reaccion _____

Other allergies? Describe
Otras alergias? Describa _____

Family History
Heart disease under age 50?
Enfermedad del corazon antes de la edad de 50 ? _____
Hereditary diseases?
Enfermedades hereditarias? _____ **Other?**
Otra? _____

Use this space for other information you wish to provide.
Use este espacio para cualquier otra informacion que desee _____

_____

Parents signature
Firma de los padres _____ **Today's date**
Fecha de hoy _____

DOCTOR'S SIGNATURE _____ **DATE REVIEWED** _____

PLEASE PRINT CAREFULLY AND ANSWER ALL QUESTIONS

POR FAVOR ESCRIBA CON LETRA DE MOLDE Y CONTESTE TODAS LAS PREGUNTAS

NAMES OF CHILDREN IN ORDER OF AGE (OLDEST CHILD FIRST)

NOMBRE DE SUS NINOS EN ORDEN DE EDAD (EL MAYOR PRIMERO)

1_____ Ethnicity_____ SEX_____ DOB_____
Fecha De Nacimiento

2_____ Ethnicity_____ SEX_____ DOB_____

3_____ Ethnicity_____ SEX_____ DOB_____

4_____ Ethnicity_____ SEX_____ DOB_____

5_____ Ethnicity_____ SEX_____ DOB_____

ADDRESS_____ **CITY,STATE,ZIP**_____
DOMICILIO DE CASA *CIUDAD/ESTADO/CODIGO POSTAL*

HOME PHONE_____ **MOM'S CELL**_____ **DAD'S CELL**_____ **CHILD'S CELL**_____
TELEFONO DE CASA *CELLULAR DE MAMA* *CELLULAR DE PAPA* *CELLULAR DE PATIENTE*

MOM'S EMAIL_____ **DAD'S EMAIL**_____
CORREO ELECTRONICO DE MAMA *CORREO ELECTRONICO DE PAPA*

FATHER'S NAME (or GUARDIAN)_____ **BIRTHDATE**_____ **LIVES IN HOME? YES___NO___**
NOMBRE DEL PAPA *FECHA DE NACIMIENTO* *VIVE EN CASA?*

MOTHER'S NAME (or GUARDIAN)_____ **BIRTHDATE**_____ **LIVES IN HOME? YES___NO___**
NOMBRE DE LA MAMA

WORK/*TRABAJO*

FATHER---EMPLOYED BY_____ **OCCUPATION**_____ **WORK PHONE**_____
PAPA EMPLEADO POR *TELEFONO*

MOTHER---EMPLOYED BY_____ **OCCUPATION**_____ **WORK PHONE**_____
MAMA EMPLEADO POR *TELEFONO*

PRIMARY INSURANCE---NAME/TYPE OF INSURANCE_____
SEGURO PRIMARIO NOMBRE/TYPO DE SEGURO

NAME OF GUARANTOR_____ **SOCIAL SECURITY NUMBER**_____ **DOB**_____
NOBRE DE PERSONA RESPONSIBLE *NUMERO DE SEGURO SOCIAL*

SECONDARY INSURANCE---NAME/TYPE OF INSURANCE_____

NAME OF GUARANTOR_____ **SOCIAL SECURITY NUMBER**_____ **DOB**_____

PERSON TO BE CONTACTED IN AN EMERGENCY OTHER THAN PARENTS (*CONTACTO DE EMERGENCIA)*

NAME_____ **HOME PHONE**_____ **CELL PHONE**_____
NOMBRE *TELEFONO DE CASA* *CELLULAR*

I HEREBY GIVE PREMISSION FOR THE TREATMENT OF MY CHILD/CHILDREN BY DRS. A. NOVOM, G. PETTERSON, K. FOLLMAR, P. NOVOM and MS B. SONNE. I HEREBY ASSIGN ALL BENEFITS OF MY INSURANCE POLICY (S) FOR MEDICAL, SURGICAL AND LABORATORY TO THE SAN PEDRO PEDIATRIC MEDICAL GROUP, INC. I FURTHER AGREE TO PAY ANY BALANCE THAT IS DUE AND PAYABLE

YO DOY PERMISO A LOS DOCTORES A. NOVOM, G. PETTERSON, K. FOLLMAR, P. NOVOM Y MS B. SONNE PARA QUE DEN TRATAMIENTO A MIS NINO/NINOS. YO DESIGNO TODOS LOS BENEFICIOS DE MI POLIZA DE SEGUROS POR SERVICIOS MEDICOS, DE CIRUGIA, DE LABORATORIO A SAN PEDRO PEDIATRIC MEDICAL GROUP, INC. YO PAGARE CUALQUIER BALANCE QUE SE DEBE

DATE_____ **SIGNATURE**_____
FECHA *FIRMA*

San Pedro Pediatric Medical Group, INC.

Consent for Treatment, Billing and Release of Information

Patient Information:

Last Name First Name Date of Birth

I consent to medical and/or surgical treatment including but not limited to x-rays, laboratory tests, and other diagnostic studies as is necessary.

I agree that to the extent necessary to determine liability for payments and to obtain reimbursement, San Pedro Pediatric Medical Group may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the charges incurred. This may include but not be limited to insurance companies, health care service plans, or worker's compensation carriers.

I understand that any employer requested medical care, including but not limited to pre-placement physical, drug testing, fitness-for-duty examinations, information needed for the employer to comply with Occupational Safety and Health Administration (OSHA), Mine Safety and Health Administration (MSHA) standards or work-related injury or illness will be disclosed directly to the requesting employer.

I irrevocably assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. A $35.00 charge will be applied to all returned checks for insufficient funds. A photocopy of this document is as valid and effective as the original.

I HAVE READ AND UNDERSTAND THE ABOVE

X_____

Patient of Parental/Guardian Signature (in the case of minors) Date

Print Name

Relationship to patient: [ ] Self [ ] Parent [ ] Guardian [ ] Other:_____

Please state

Notice of Privacy Practices
Acknowledgement of Receipt

I have received the Notice of Privacy Practices

Signature:_____ Date:_____

Patient/Financially Responsible Party

Relationship, **if other than patient**: [ ] Parent [ ] Sibling [ ] Guardian
[ ] Other: (specify)_____

Account Number_____

To be completed by office staff