ColumbiaDoctors

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: ___/___/___

Preferred Phone: _____ Email: _____ Gender: _____

Primary Pediatrician: _____ Phone: _____

Pediatrician Address: _____

Referring Provider: _____ Phone: _____

Referring Address: _____

Preferred Pharmacy: _____ Phone: _____

Preferred Pharmacy Address: _____

Parent 1 Name: _____ DOB: ___/___/___

Phone: _____ Email: _____

Occupation: _____ Marital Status: _____ Spouse: _____

Parent 2 Name: _____ DOB: ___/___/___

Phone: _____ Email: _____

Occupation: _____ Marital Status: _____ Spouse: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

☐ Decline Response

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race:

☐ Decline Response

☐ American-Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Pacific Islander

☐ White

☐ Other

Preferred Language: _____ ☐ Decline Response

Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____

Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

Patient Name (Print): _____

Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____

Representative Signature: _____ Date: _____

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Medical and Social History

Reason for today's visit: _____

Is your child adopted? Y N *If 'Y', please answer the following to the best of your knowledge.*

Which pregnancy is this child? _____ Birth weight: _____ Born by: ☐ C-Section ☐ Vaginal Delivery

Months' gestation at birth? _____ If C-section, why? _____

Please describe any health problems the mother or child experienced during pregnancy or after birth, if any:

Does your child have any allergies to medications or other substances? Y N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis). _____

Please list ALL of your child's current medications, including over-the-counter, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Please use the back of the page if additional space is needed.

Please list any surgeries your child has had and the approximate date. _____

Have your child EVER had any of the following?

Anemia/Bleeding tendency	Y	N	Ear/Nose/Throat	Y	N
Asthma/Breathing problems	Y	N	Eczema/Skin disorder	Y	N
Behavioral problems	Y	N	Eye Disorder	Y	N
Blood Transfusion	Y	N	Growth disorder	Y	N
Bowel/Stomach problems	Y	N	Heart disorder/defect	Y	N
Cancer/Leukemia	Y	N	Kidney/Bladder problems	Y	N
Chicken Pox/Shingles	Y	N	Liver disease	Y	N
Developmental disorder	Y	N	Seizure or Epilepsy	Y	N
Diabetes	Y	N	Thyroid disorder	Y	N

Please list any other medical illnesses or problems and provide details for any of the above conditions.

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Other:		Y N	

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to patient

Does anyone in living in your home smoke? Y N Do you have pets? Y N

Provider Signature: _____ Date: _____