Stepping Stone Pediatrics, LLC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Child's Name: ____Today's Date: __________________
Last Name First Name Middle

Child's Birth date: ________________ Sex: Male Female Child's Nickname: _________________

Please list **all** those living in the child's home (parents, grandparents, etc).

Name	Relationship to child	Age	Health Problems

Is there a smoker living in the child's home?
Yes No Whom? _____________

If mother and father are not living together, with whom does the child live?
____

Birth History- for children **less than** 5 years of age.

Birth Weight ________________ Apgar _____________

At how many weeks gestation was the baby born? _____

Did mother have regular prenatal care? Yes No

Did mother have any illness or problem with her pregnancy?
Yes No Explain _____________________________

During pregnancy, did mother:
Smoke Yes No Drink alcohol Yes No
Use drugs or medication Yes No
What ________________ When _____________________

Was the delivery Vaginal? Caesarean?
If cesarean, why? _____________________
Did your baby have any problems right after birth?
Yes No Explain
____

Was initial feeding Breast? Bottle?
Did your baby go home with mother from the hospital?
Yes No Explain
____

General

Do you consider your child to be in good health? Yes No Explain________________________
Does your child have any serious illness or medical condition? Yes No Explain________________________
Has your child had any serious injuries or accidents? Yes No Explain ________________________
Has your child had any surgery? Yes No Explain ________________________
Has your child ever been hospitalized since birth? Yes No Explain ________________________
Is your child taking any medications, including vitamins, minerals, or herbal supplements? Yes No Explain________________________
Is your child allergic to any medications or drugs? Yes No Explain________________________
Any allergies to foods or insect bites/stings? Yes No Explain________________________

Development

Are you concerned about your child's physical development? Yes No Explain ________________________
Are you concerned about your child's mental/emotional development? Yes No Explain ________________________
Are you concerned about your child's attention span? Yes No Explain ________________________
Does your child have any problems speaking? Yes No Explain ________________________
If in school, how is your child doing in academic subjects? Explain ____________________________________
Has your child shown signs of puberty? Yes No If a girl, at what age was her first menstruation? _____

Past History

Does your child have, or has he/she ever had any of the following.

Chickenpox	Yes	No	Bladder or kidney infection	Yes	No
Frequent ear infections	Yes	No	Bed wetting (after 5 yrs old)	Yes	No
Problems with hearing	Yes	No	Any chronic skin problems	Yes	No
Nasal allergies	Yes	No	Frequent headaches	Yes	No
Problems with eyes / vision	Yes	No	Convulsions/seizures	Yes	No
Asthma, bronchiolitis, pneumonia	Yes	No	Neurological problem	Yes	No
Any heart problem or heart murmur	Yes	No	Diabetes	Yes	No
Anemia or bleeding problem	Yes	No	Thyroid or other endocrine problem	Yes	No
Blood transfusion	Yes	No	Any other significant problem	Yes	No
Frequent abdominal pain	Yes	No	Use of alcohol or drugs	Yes	No
Constipation requiring doctor visits	Yes	No	Use of tobacco products	Yes	No

Please elaborate on any yes responses:

____

____

____

____

Family History

Have any family members from mother's and father's side had the following:

Deafness	Yes	No	Kidney disease	Yes	No
Nasal allergies	Yes	No	Bed wetting (after 10 yrs old)	Yes	No
Asthma	Yes	No	Convulsions/seizures	Yes	No
Tuberculosis	Yes	No	Diabetes (before 50 years old)	Yes	No
Heart disease (before 50 years old)	Yes	No	Alcohol abuse	Yes	No
Unexplained or sudden death (before 50 yrs)	Yes	No	Drug abuse	Yes	No
High blood pressure (before 50 yrs old)	Yes	No	Mental illness	Yes	No
High cholesterol	Yes	No	Mental retardation	Yes	No
Anemia or bleeding problem	Yes	No	Immune problems, HIV, or AIDS	Yes	No
Liver disease	Yes	No	Any other significant problems	Yes	No

Please elaborate on any yes responses:

____

____

____

____

Please let us know who referred your family to us so that we may thank them. __________________________

Who is completing this form: __________________________ Relationship to child: _________________________

Signature ____ Date: _________________________________

Updated Information Sheet- **Stepping Stone Pediatrics, LLC**

We are pleased that your family continues to be a member of our family. Please take a few minutes to fill out this form as completely as you can. This insures that we have the **most up to date** information regarding you and your children. If you have questions weql be glad to help you.

Todayqs Date: _________________

Family members (children) this form applies to:

Last name	First	Birthdate

Last name	First	Birthdate

Childqs Primary Address: ____
Street City Zip

Telephone: ___________________________

Language (s) spoke at home: ________________________

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: American Indian or Alaskan Native Asian Black White
Hawaiian Native or Pacific Islander

Pharmacy the family uses: Name: ___________________________, City: ________________, Phone _____________

Notice of Privacy Practices

I, _____________________, have received a copy of Stepping Stone Pediatricsqnotice of privacy practices.
Parent/guardianqs name

___________________________ ___________________
Signature of parent/ legal guardian Date

HIPAA Authorizations

By signing this authorization, I authorize Stepping Stone Pediatrics to use and/or disclose certain protected health information (PHI) about the children above for the purposes indicated below. I do not have to sign this authorization in order to have my child receive treatment from Stepping Stone Pediatrics. In fact, I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Stepping Stone PediatricsqPrivacy Officer.
This authorization expires two years after the date it was signed.

Alternative caregivers: We realize at certain times a parent/guardian might not be able to accompany a child to our office to see the pediatrician. We do request that for **well visits** a **parent** be present as we exchange important information regarding your childqs health, growth and development. For sick visits do you authorize an alternative caregiver (for example grandparent, baby sitter) to have access to your childqs PHI?
Ç Yes I authorize Ç No, I do not authorize Signature __________________________ Date ____________

School / Camp physical forms: Do you authorize SSP to complete and forward to the appropriate place school and camp forms as provided to us by you?
Ç Yes I authorize Ç No, I do not authorize Signature __________________________ Date ____________

Communications: So you authorize SSP to leave information on a home answering machine?
Ç Yes I authorize Ç No, I do not authorize Signature __________________________ Date ____________

Please continue on other side ----------------------→

Emergency Contacts: If we need to reach you in an emergency, please provide information on someone **not** living in your home.
Emergency Contact ______________________________________ Relation to child ___________________
Phones: Home _________________ Work __________________ Other _______________________

In the 3rd column **BELOW** please place the following indicators of how you would like to be contacted about your child / children:

A = Appointment confirmation / reminder for an appointment already made

R = reminder that an physical is needed or a vaccine is due

B = Billing statements **note** only to mail address, text to cell, or email

G = general notices and medical issue

Mother's Information: Name: ___________________________ Birth date: _____________ Occupation: ____________________ Smoker: Yes No Lives with child / children: Yes No Address if different from above:	Cell Phone	
	Text to cell phone	
	Email	
	Work phone	
	Home land line (if different from front)	
Father's Information: Name: ___________________________ Birth date: _____________ Occupation: ____________________ Smoker: Yes No Lives with child / children: Yes No Address if different from above:	Cell Phone	
	Text to cell phone	
	Email	
	Work phone	
	Home Land line (if different from front)	

Insurance

Person Responsible for account ______________________________________ Relation to child__ ___________
Last Name First Name Middle

Primary Insurance Company ____ Phone ___________________

Are patients covered by secondary insurance? Ç yes Ç no

Secondary Insurance: If secondary insurance member is different from person responsible for account, please provide the following:

Person Responsible for account ______________________________________ Relation to child _____________
Last Name First Name Middle

Secondary Insurance Company _______________________________________Phone ___________________

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the doctor to release the minimum necessary information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____ Date: _______________________