



Carolinah HealthCare System

ACKNOWLEDGEMENT FORM

Medical Records # _____

Patient's Name: _____ Date of Birth ____/____/____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date: _____
(Patient or Authorized Representative)

Relationship to Patient: _____ Self _____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

ACKNOWLEDGEMENT FORM

DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICIANS NETWORK

Numero de Registro Medico _____

Nombre del Paciente _____ Fecha de Nacimiento ____/____/____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representante Autorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Firmar: _____



Carolinus HealthCare System

HIPAA* Authorization Form

Patient Name: _____ DOB: _____

Do you agree to share information (lab results, medication requests, appointments, billing information, etc.) with anyone?

- No, I do not wish to share any information
- Yes (please fill in additional information)

Contact Name	Contact Number	Relationship	Comments

Signature: _____ Date: _____

Printed Name (if other than the patient): _____

Relationship: _____

PEDIATRIC PATIENT HISTORY

Today's date _____

Child's name _____ Birthdate _____ Sex: male female

Mother _____ Birthdate _____

Address _____ Phone _____

Father _____ Birthdate _____

Address _____ Phone _____

Legal guardian (if other than parent) _____ Phone _____

Address _____

Siblings (names and birthdates)

Parents are: married ___ single ___ separated ___ divorced ___

Members of household _____

Pets in the home _____ Smokers in the home _____

How old is home? _____ Water fluoridated? yes ___ no ___

Diet _____

Does child attend daycare or afterschool program? _____

Does your child attend church or community program? _____

Comments _____

ALLERGIES (please list) _____

BIRTH HISTORY

Length of pregnancy _____ Type of delivery: vaginal _____ C-section _____

Weight _____ Length _____ Apgar scores _____ / _____

Type of feeding: breast _____ formula (name) _____

Complications during pregnancy, labor or delivery _____

Problems in nursery _____

DEVELOPMENT

 At what age did the child first:

Roll over _____ Sit alone _____ Speak single words _____

Crawl _____ Walk alone _____ Make sentences _____

Toilet train _____

Did the child have any of the following problems during the first few months of life? (circle if yes)

jaundice anemia breathing difficulty

trouble feeding seizures blue spells

severe colic infections required oxygen

CHILDHOOD ILLNESSES

 Has the child had any of the following? (circle if yes)

chicken pox meningitis tubes in ears pneumonia

asthma/wheezing seizure heart murmur frequent ear infections

Other chronic or ongoing medical problems _____

HOSPITALIZATIONS (for surgery, accidents or injuries). List date and reason for hospitalization

MEDICATIONS List all including vitamins, fluoride, iron, prescription and non prescription drugs.

FAMILY HISTORY Do any of the child's close relatives (parents, grandparents, brothers or sisters) have any of the following? (circle if yes)

High blood pressure	Diabetes	Allergic disease	Seizures
Heart disease	Bleeding disorders	Asthma	Kidney disease
Sickle cell	Cystic fibrosis	Alcoholism	High cholesterol
Cancer	Mental problems		

IMMUNIZATIONS Please provide us with a current list of all immunizations received.

DOES THE CHILD HAVE ANY UNUSUAL PROBLEM WITH (circle if yes)

behavior	temper tantrums	nightmares	trouble in school
discipline	vision	bedwetting	learning difficulty
breathholding	speech	toilet training	attention deficit
hyperactivity	thumbsucking	snores	difficulty sleeping

WHAT RECENT PROBLEMS HAS THE CHILD HAD? _____

WHAT CONCERNS DO YOU HAVE TODAY?
