

**Pediatric Patient Medical History**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's date \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_ Father/Guardian Name \_\_\_\_\_

School/Daycare \_\_\_\_\_ Who referred you? \_\_\_\_\_

What is the problem that brought you in today? \_\_\_\_\_

\_\_\_\_\_

Date or Age Problem Started \_\_\_\_\_ Is it getting worse/better/unchanged? \_\_\_\_\_

Have you had any work up/treatment for this before? \_\_\_\_\_

\_\_\_\_\_

Have you had any Imaging (X-Ray/US/CT scan/MRI)? \_\_\_\_\_

**Please List all the Health care professionals involved in your care and their address:**

Pediatrician/Family Doctor \_\_\_\_\_

Specialist \_\_\_\_\_

Specialist \_\_\_\_\_

Physical Therapist \_\_\_\_\_

Chiropractor/Manual Therapist \_\_\_\_\_

**Current Medications (include vitamins and herbs):**

**Allergies - Please describe reaction :**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Problems for which you see a doctor:**

**Previous Surgeries or Hospitalizations (Include date):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Sport(s) Played:** \_\_\_\_\_

**Previous traumatic injuries (Concussions, Broken bones, Falls, Stitches):** \_\_\_\_\_

\_\_\_\_\_

**Family History:** Year Born: \_\_\_\_\_ Health Problems: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Sister(s): \_\_\_\_\_

Brother(s): \_\_\_\_\_

Who do you live with (Include Pets): \_\_\_\_\_

Have you traveled in the Last year (where/when)? \_\_\_\_\_

Are you exposed to smoke? Y / N I am a smoker \_\_\_\_\_ Pks/Day Caffeine? \_\_\_\_\_ Cups/Day

\_\_\_\_\_ **BELOW IS FOR CHILDREN 5 YEARS OLD OR YOUNGER ONLY** \_\_\_\_\_

**BIRTH HISTORY:** Born On Time or Early? \_\_\_\_\_ Birth Weight? \_\_\_\_\_

Vaginal Delivery or C-Section? \_\_\_\_\_ Vacuum/Forceps used? \_\_\_\_\_

Any problems with the delivery? \_\_\_\_\_ Any Problems with the Pregnancy? \_\_\_\_\_

Any problems right after birth (ex Jaundice)? \_\_\_\_\_

\_\_\_\_\_ **BELOW IS FOR INFANTS 12 MONTHS OLD OR YOUNGER ONLY** \_\_\_\_\_

**Breast Feeding:** \_\_\_\_\_ Minutes every \_\_\_\_\_ hrs (aprox) I use a Nipple Shield: Y / N

**Supplementation:** After/ During / Before breastfeeding \_\_\_\_\_ ounces of: breast milk/formula \_\_\_\_\_

To supplement I use: a bottle S+S syringe at the breast Syringe with finger finger feed no syringe cup feed

List Lactation consultants you are/have seen \_\_\_\_\_

I breast fed until age \_\_\_\_\_ but stopped because \_\_\_\_\_

**Bottle Feeding** \_\_\_\_\_ Ounces every \_\_\_\_\_ hrs

**Solid foods:** I have / have not started solids

Describe any difficulties with eating solids: \_\_\_\_\_



Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F / T  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Preferred method of communication (circle one):  Voice  SMS/TEXT Message  Email (for appt reminder only)

Marital Status: Married Single Divorced Widowed Partner  
Race: African American American Indian Asian White Hispanic Pacific Islander Other  
Ethnicity: Hispanic Non-Hispanic Prefer Not to Report Preferred Language: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Student Status: Full Time / Part Time Location/ School: \_\_\_\_\_

Responsible Party Info: (if patient is a minor):  
Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Is this a foster child? Yes / No If yes, Primary Caregiver/Legal Guardian's Name: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have Medical Insurance? Yes / No  
Primary Insurance Company: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Policy Holder's Info: (if different from the patient):  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Policy Holder's Address: (if different from the patient):  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Demog Packet 01/14/2021



**Consent for Treatment**

I hereby consent to medical treatment, diagnostic tests, laboratory, and other medical procedures, which the physician(s) or healthcare provider(s) of VSOM may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Privacy Practices**

I acknowledge that I have access to a copy of VSOM Privacy Practices and that it is my responsibility to read the notice to understand how my or my child(ren)'s Protected Health Information may be used.

I understand no authorization is required from me for VSOM to use my or my child(ren)'s Protected Health Information for purposes of treatment, payment or health care operations. Other uses or disclosures may require my written authorization. **\*\*If you would like a copy of VSOM's Privacy Practices, please ask the receptionist.\*\***

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement of Deemed Consent for HIV / Hepatitis B or C Virus Blood Testing**

Virginia Law authorizes health care providers to test their patients for HIV antibodies or Hepatitis B or C viruses when the health care provider is exposed to body fluids (ie: needlestick) of a patient in a manner which may transmit HIV or Hepatitis B or C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for these antibodies pursuant to this provision, the testing would be explained, and the testing would be explained, and you would be given the opportunity to ask any questions you might have. Patients who test positive will also be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Agreement**

I agree to be financially responsible for costs incurred in my or my dependents care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by VSOM on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to VSOM (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my insurance carrier. I agree that I am responsible for satisfying any conditions (referrals) necessary for insurance or health benefits.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received services rendered by VSOM and agree to pay for said medical services according to such terms.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Self-Pay Agreement**

I agree to pay for medical services rendered at VSOM. I understand that there are payment plans available at my request. I understand that these plans will be based on my financial income and will be reviewed prior to approval.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Authorization to Treat in Absence of Parent or Guardian (optional)**

If my child(ren) is/are brought in to the office by \_\_\_\_\_, I consent for my child(ren) to be treated and agree to be financially responsible for the cost of such care. I understand that by not signing this section my child(ren) cannot be seen at VSOM without myself or another legal guardian present.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorized Person(s) for Protected Health Information Disclosure**

I hereby authorize VSOM to disclose my medical and Protected Health Information to the person(s) indicated below:

| Name  | Relationship | Phone # |
|-------|--------------|---------|
| _____ | _____        | _____   |
| _____ | _____        | _____   |

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization for Release of Confidential Health Care Information**

This authorizes VSOM to request and receive from the Virginia Department of Health Professions any and all records held by the department relating to schedule 2-5 controlled substances dispensed to the patient named above. I understand that this authorization permits the Dept. of Health Professions to disclose confidential health care records to the prescriber named above (VSOM). A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law. I understand that, if not previously revoked, this consent will expire one year after the date of my signature, unless otherwise specified.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notification of Appointments /Treatments**

VSOM makes every effort to use your preferred method of communication for appointment reminders, clinical care including laboratory results or any other issues regarding your account with us. With this consent, VSOM may call home, cell or other designated location and leave message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others. We will use the information you have provided, and may consist of leaving messages on voicemail, email, letters, etc.

By signing below, you are giving permission for VSOM to leave messages on voicemail and speak with the designated person(s) that are listed on the PHI Disclosure.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Late Cancellation and No-Show Policy

Late cancellation and no-shows for appointments unnecessarily delay the delivery of health care to other patients.

Late Cancellation and No-Show Policy:

- A late cancellation is defined as failure to contact the office at least 24 hours in advance to cancel the appointment. There will be a \$50 charge for late cancellations all patients. This is not billable to the insurance and is due prior to scheduling another appointment.
- A no-show is defined as missing a scheduled appointment. There will be a \$50 charge for no-show appointments. This is not billable to the insurance and is due prior to scheduling another appointment.
- NEW PATIENTS who miss TWO consecutive initial office without giving the office at least 24-hour notice may not be permitted to schedule another appointment.
- ESTABLISHED patients who miss THREE scheduled appointments (within a year) without giving the office at least 24-hour notice may be dismissed from the practice.

Late Arrivals Policy:

If you are more than ten minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day but is not always an option.

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### VSOM Notice

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Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Are you (or the person being seen) a VCOM student or a VCOM student family member? Yes \_\_\_ No \_\_\_

Please note: If you answered yes to the above question, it is the policy of VSOM that no other medical student be involved in your or your dependents care. Please notify your nurse upon triage.



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Marital Status: Married Single Divorced Widowed Partner  
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Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Student Status: Full Time / Part Time Location/ School: \_\_\_\_\_

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