ALLIED PEDIATRICS

7405 Shallowford Rd Ste 270, Chattanooga, TN 37421-2662 5564 Little Debbie Pkwy Ste 114, Ooltewah, TN 37363-4356
email | info@MyAlliedPediatrics.com web | www.MyAlliedPediatrics.com tel | 423-602-9545 fax | 423-602-9546

Welcome to Allied Pediatrics,

We are happy that you have chosen to bring your child to our office. We have prepared this packet of information in order to make your first visit a convenient and pleasant experience. We ask that you please complete this paperwork and either bring it to either of our offices, FAX or mail it to us before your first visit. Our contact information is on the letterhead above.

When you come for your appointment, please bring the following:

- **Medical Insurance Card:** If no card is submitted at the time of your appointment, you will be asked to pay privately or reschedule your appointment.
- **Release of Records:** Please complete a separate release form for each doctor your child has seen. If you have a copy of your child's medical records, please bring those to the first appointment. If we do not have your child's past medical records by their first appointment, we will not be able to refill medications, give vaccines, or give a vaccine certificate for school at that visit.
- **Credit Card:** Office policy requires a credit card on file.
- **Vaccine Record**
- A complete list of all medications, vitamins, minerals, supplements, and herbs including the strengths and dosages.
- Completed Patient Registration
    - Signed patient privacy form
    - Vaccine policy
    - Financial policy
    - Authorization to release medical records
    - Information for new patients
    - HIPPA form
    - Policy for Charges
    - Authorization for alternate caretakers
    - New patient health history form

Please be prepared to pay for the following at the time of your visit:

- Co-payment. Our office accepts cash, checks, VISA or Master Card for the co-payment.
- If you do not have insurance, please call our billing office and we will give you an estimate of what the cost of the visit will be. Payment is expected at the time of the service.

Please be prepared to pay possible additional charges:

- If your child has already had an age-specific well check billed to insurance (ex. 2 month well check), there will be a $50 charge if you request an additional well check not covered by your insurance.
- If your child is needing a school physical, which is typically not covered by insurance, there will be a $50 charge at the time of service.

If your child has TN Medicaid, please be sure to contact their insurance company and request a PCP change.

If you have a FOSTER CHILD or CUSTODY of a child, the paperwork indicating this status should be brought to the office prior to your first appointment. Without the needed paperwork in the chart, we will not be able to see the child.

Patients without proof of insurance are expected to pay for services on the date of service. If for some reason you are not able to, it is your responsibility to make arrangements to set up a payment plan. Patients who do not pay their bills will be turned over to a collection company and will be dismissed from the practice.

Office hours for both locations are Monday through Friday 8:00am-5:00pm.

Looking forward to meeting you and your family soon!

Sincerely,

Allied Pediatrics

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Patient Demographic Form

How did you hear about Allied Pediatrics (choose one)?

- ❑ Community event
- ❑ Employer health fair
- ❑ Facebook ad
- ❑ Facebook event
- ❑ Facebook friend
- ❑ Family
- ❑ Friend
- ❑ Hospital
- ❑ Insurance company
- ❑ Lactation specialist
- ❑ Midwife or doula
- ❑ OB
- ❑ School advertising
- ❑ School event
- ❑ Search engine (e.g. Google, Bing)
- ❑ Street sign
- ❑ Urgent care

Patient Information

Last Name _____ First Name _____ Middle Initial ____

Nickname _____ Gender ❑ Male ❑ Female

Date of Birth _____ Social Security Number _____

Home Address _____ Apt# _____

City _____ State _____ Zip Code_____

Home Phone _____

Responsible Party (Guarantor) Information

Relationship to Patient ❑ Self (*if self, skip to Next of Kin*) ❑ Spouse ❑ Parent ❑ Other

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Social Security Number _____

Home Address_____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Other Phone _____ Email _____

Employer _____ Employment Status _____

Emergency/Next of Kin Contact Information

Last Name _____ First Name _____

Relationship to Patient _____

Home Address_____ Apt# _____

City _____ State _____ Zip Code _____

Home phone _____ Work phone _____

Allied Pediatrics

Recommended Vaccine Schedule

Providers at Allied Pediatrics strongly believe that vaccines save lives and are proponents of preventative medicine

Patient Name:_____ DOB: _____

Parent Signature:_____ Date Signed: _____

2 month well check*	Hib, Pediarix (dtap, hep B, polio), Prevnar, Rotarix (oral)
4 month*	Hib, Pediarix (dtap, hep B, polio), Prevnar, Rotarix (oral)
6 month*	Hib, Pediarix (dtap, hep B, polio), Prevnar
9 month*	No vaccines
12 month*	Hep A, MMR, Prevnar, Varivax
15 month*	Dtap, Hib
18 month*	Hep A
4 year well check*	Kinrix (Dtap, polio), MMR, Varivax

The * denotes regular well-checks. The visits in between are for vaccinations only and will require a scheduled appointment with a co-pay.

Allied Pediatrics recognizes that some parents have concerns about the recommended vaccine schedule, even though we fully support the recommended CDC/AAP schedule - this is how we can support you.

Once this schedule is agreed on and signed by the parent/guardian, it will be a permanent part of the patient's chart and no deviations will be allowed.

Patients who do not receive vaccinations according to the recommended schedule can contract the illnesses that vaccinations prevent and can transmit the illnessess to others who may be too young to vaccinate or who may have immune problems.

If your child is not fully vaccinated against a particular disease and there is an outbreak of that illness, your child may be required to stay home from school or daycare until the outbreak is over.

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Patient Authorization to Release Medical Records

Patient Information

Name of Patient _____ Date of Birth _____

Doctor/Facility to PROVIDE records

Name of Doctor/Facility _____

Phone # _____ Fax # _____

Doctor/Facility to RECEIVE Records

Name of Doctor/Facility Allied Pediatrics

Phone # 423-602-9545 Fax # 423-602-9546

Records TO BE Released

For the purpose of continuity of care, initial one box indicating which records you would like sent

[ ] All Medical Records (complete copy including test results, labs, X-rays, photos, reports, dictations and all records from other physicians)
[ ] Medical Records for specific date of service (date date/s) _____

Expiration or Revocation of Authorization

I understand that I may revoke this authorization at any time and that, unless an earlier date is specified, it will automatically expire 12 months after the date below.

_____ _____
Signature of patient or guardian Name of patient or guardian

_____ _____
Relationship if guardian Date

If with Power of Attorney please attach supporting documentation.

Information for New Patients

*Please initial these policies indicating that you have read, understand and **agree** to comply with each

1. **After Hours -** Office hours are 8:00 AM to 5:00 PM Monday through Friday. If you have a medical emergency after office hours call 911 or go to your nearest Emergency Department. For non-emergent sickness after hours go to your nearest Urgent Care. Refilling prescriptions are not an emergency. If you need to speak to a provider outside of normal business hours, please call 423-602-9545 and leave a message and you call will be returned within 1 hour.

_____

2. **Immunization -** We support the importance of immunizing children according to the American Academy of Pediatrics immunization schedule. We accept only those patients who plan on vaccinating their children. I plan on vaccinating my children.

_____

3. **Missed Appointment/NO-SHOW -** If you are unable to keep your scheduled appointment contact us at least 24 hours in advance. **If you miss three appointments you will be dismissed from the practice.** Late cancellations and missed appointments are subject to a $50.00 fee. Missed well checks/physicals are subject to a $100.00 fee. Missed procedures are subject to a $200.00 fee.

_____

4. **Coming Late -** If you are more than 10 minutes late for your appointment, you will be asked to reschedule. If you contact the office with a valid reason for being late, the provider will determine, depending on the schedule, if they can still see you or not.

_____

5. **Insurance Verification -** Patients must provide an active insurance card at each visit. Without this information, patients may be rescheduled or registered as self-pay.

_____

6. **Insurance Benefits -** It is the patient's responsibility to know his/her insurance benefits including wellness benefits prior to time of service.

_____

7. **Insurance Co-Pay -** Due at the time of service. When a patient is diagnosed with a problem during a well check, a co-pay may be required, depending on how insurance processes the claim.

_____

8. **Insurance Deductibles and Co-insurance -** Due upon receiving the mailed statement. Patients will be asked to settle any outstanding amounts before their next appointment.

_____

9. **Insurance Deductibles and Co-insurance -** Due upon receiving the mailed statement. Patients will be asked to settle any outstanding amounts before their next appointment.

_____

10. **Patient Balances -** Our electronic system will automatically send patient balances, which are not resolved in a timely manner, to an outside collection agency and additional collection fees may be added.

_____

11. **Patient Self-Pay -** We recognize that not every patient has insurance. We strive to work with patients to manage their healthcare expenses. Payment plans can be set up by calling during office hours.

_____

12. **Billing Claims to Insurance -** Our office will send claims on behalf of patients to their insurance company(s). After insurance processing any remaining balances will be billed to the patient for payment. If insurance denies payment due to information needed from the patient, the entire payment will be billed to the patient until information has been submitted to the insurance company and our office has been notified.

_____

13. **Payments –** Payments can be made at or mailed to:

    Allied Pediatrics
    7405 Shallowford Rd Ste 270
    Chattanooga, TN 37421-2662

14. **Newborns –** Newborns are covered under their mother's medical insurance for the first 30 days provided that the insurance company was informed of the child's birth. After 30 days the child will be seen as a self-pay patient until they have their own insurance and the information has been provided to Allied Pediatrics.

_____

15. **Co-Payment Information –** If you bring in your child for a well check, typically there is no co-pay. However, if the provider finds a medical problem that needs to be addressed during the well check, or needs to/is requested to address an existing medical problem, it has to be noted in the patient's chart and reported to your insurance company. This may result in a co-pay for the visit depending on how your insurance company processes the claim.

_____

16. **Sick Visits –** The best time to call for a same day sick visit is between 8am - 10am. We do reserve a number of openings for these visits; however, they are available on a “first call first seen” basis. We do expect that you keep that appointment once scheduled.

_____

17. **Legal Custody –** Paperwork indicating who the legal custodian of the patient is has to be on file at the office.

_____

18. **Personal Bio –** Inform the office every time you change your address, phone number, name or insurance information.

_____

_____ _____

Signature of Patient or Guardian Date

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Financial Policy

Insurance Verification:

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Allied Pediatrics makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance:

Insurance companies require Allied Pediatrics to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits required in advance for services not covered by the patient's insurance.

Outstanding Balances:

Patients will be asked to settle any outstanding balances with Allied Pediatrics before their appointment. As a patient, you may pay any outstanding balances at our office or you may go to our website at www.myalliedpediatrics.com.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balance which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay:

Allied Pediatrics recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Allied Pediatrics will try to work with the patients to help them anticipate charges and manage their healthcare expenses. Patients without insurance who pay in full at the time of service may be eligible for a discount.

Billing Insurance:

Allied Pediatrics contracts with most insurance companies for patient services. The patient remains financially responsible for all his/her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received.

No-Show and Late Cancellation Fee:

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $50.00 fee, not for any service, but for the lost opportunity to see another patient. This fee may be higher for procedures other than routine office visits.

Payments:

Allied Pediatrics accepts cash, check, Visa, Mastercard or Discover. There is a $30.00 fee for all returned checks. Payments can be made at or mailed to:

Allied Pediatrics
7405 Shallowford Road Ste. 270
Chattanooga, TN 37421

If you have any questions regarding our financial policies, please contact our office at (423)602-9545.

Note:

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay all costs associated with such collection activity, including reasonable collection agency fees, attorney fees and court costs.

_____ _____

Patient Signature or Responsible Party Date

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Notice of Personal Health Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

We reserve the right to revise or amend our Notice of privacy practice without additional Notice to you. Any revision or amendment to this Notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Allied Pediatrics, PLLC will post a copy of this notice as amended in a prominent place in our office and on our website.

This notice becomes effective July1, 2011 and amends our previous form of Notice. No amendment relates to any substantive right of an Allied Pediatric patient or any duty of Allied Pediatrics. If you have any questions about the Notice of Personal Health Information Practices, please contact our Privacy Officer at 423-602-9545.

Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing a medical condition, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations - Your health information may be used as necessary to support the day-to-day activities and management of Allied Pediatrics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement - Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting - Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department

Health Oversight Activities - We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include,

for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor health care system, government programs, and compliance with civil rights laws.

Family Members - We may release medical information, including mental health information, about you to the family member who is involved in your medical care without consent or authorization if the individual's involvement is related to such information. We may also give medical information, including prescription information or information concerning your appointments to friends who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Business Associates - We have contracted with other entities to provide services to Allied Pediatrics. When these "associates" require your personal health information in order to accomplish tasks asked of them by Allied Pediatrics It will be provided to them. Examples of business associates are: billing service, collection agency, answering service, insurance service, transcription service, and computer software/hardware provider.

Research/Teaching/Training - Your PHI can be used for the purpose of research, teaching and/or training.

Appointment Reminders - Your health information will be used by our staff to send appointment reminders to you.

Workers Compensation - We may release medical information about you for workers' compensation or similar programs without consent or authorization. These programs provide benefits for work-related injuries or illness. For example, if you are injured on the job, we may release information regarding that specific injury.

Marketing - Your health Information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you. In addition, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Other uses and disclosure require your authorization - Disclosure of your health information or its uses for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a release of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights - You have certain rights under the federal privacy standards.
These include:

The right to request restrictions on the use and disclosure of your protected health information
The right to receive confidential communications concerning your medical condition and treatment
The right to inspect and copy your protected health information
The right to amend or submit corrections to your protected health
The right to receive an accounting of how and to whom your protected health information has been disclosed
The right to receive a printed copy of this notice

Allied Pediatrics' Duties - We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Changes - As permitted by law, we reserve the right to amend or notify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit unless the revisions are not significant. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information - As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the medical records department of Allied Pediatrics.

Requests for Restrictions on Protected Health Information - You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to agree with your requested restriction in certain situations. These situations include emergency treatment disclosures to the Secretary of the Department of Health and Human Services, and any uses and disclosures described on the front page of the notice. However, if we decide to grant your request, we are bound by our agreement

Complaints - If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPPA Privacy Officer
Allied Pediatrics, PLLC
7405 Shallowford Road Ste 270
Chattanooga, TN 37421-2662

If you believe that your privacy rights have been violated, you should call the matter to our attention by calling the Privacy Officer at 423-602-9545 or by sending us a letter describing the cause of your concern to the address provided. You may also address any complaint to the United States Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint

_____ _____

Signature of Patient or Guardian Date

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Policy for Charges Associated with Release of Protected Health Information

A signed request for the release of Protected Health Information (PHI) is required to release medical records. Due to the expenses associated with copying and mailing medical records the following charges apply per patient.

Patient and Attorney Requests

There will be a charge to patients or attorneys who request copies of medical records.

- $25.00 for pages 1-25 plus applicable postage
- $10.00 for pages 26 and over

Once printed you will be pre-billed by Allied Pediatrics and your records will be sent once payment is received.

Healthcare Provider and Insurance Company Requests

- Free of charge

Immunization Records Requests

- Birth thru 12 months of age – Copies of immunization records will be provided free of charge once infants receive shots on a routine basis.
- Requests for immunizations records typically take at least 24hrs to process.
- 13 months thru adulthood - One copy of an immunization record will be provided free of charge per calendar year.
- One TN or GA immunization record will be completed free of charge per calendar year.
- A $10.00 charge will apply for each copy requested thereafter in the same calendar year.

Questions Regarding Release of Immunization Records

Questions regarding release of immunization records may be directed to Allied Pediatrics at (423) 602-9545.

I understand the above information regarding the charges associated with the release of my Protected Health Information (PHI).

_____ _____

Signature of Patient or Guardian Date

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Treatment Authorization Limitations

Does only one parent have custody rights? If so, please check this box and talk to our receptionist about these circumstances as we may need additional information from you.	☐
Does someone besides biological/adoptive parents care for or have custody rights of the patient (ex. family member, foster care)? If so, please check this box and discuss with our receptionist.	☐
Check here if both parents have full custody rights.	☐

Authorization for Alternate Caretakers

Allied Pediatrics understands that special circumstances may arise. If for some reason you cannot bring your child to an appointment, we allow up to 4 authorized caretakers to bring them in your place.

- I understand that alternate caretakers must have a valid ID that matches the information below or we will not be able to proceed with the appointment. _____
- I understand that alternate caretakers will have the ability to make medical decisions regarding the patient at the appointment _____
- I understand that alternate caretakers will be responsible for making payments that are due on the day of the appointment _____
- I understand that alternate caretakers will have the ability to make financial decisions regarding the patient's account on the day of the appointment _____

Patient Name: _____ Date of Birth: _____

Caretaker 1 Name: _____ Telephone #: _____

Relationship to Patient: _____

Caretaker 2 Name: _____ Telephone #: _____

Relationship to Patient: _____

Caretaker 3 Name: _____ Telephone #: _____

Relationship to Patient: _____

Parent/Guardian 1 Name: _____ Telephone #: _____

Parent/Guardian 2 Name: _____ Telephone #: _____

_____ _____

Signature of parent/guardian Date

New Patient Health History Form

Patient name _____ Date of Birth _____

Gender/Sex ❑ Male ❑ Female

Parent/Guardian name _____ Date _____

Home and Environment:

1. What is your child's living/custody arrangements (check all that apply)? ❑ birth mother ❑ birth father ❑ both parents ❑ grandparent ❑ foster parent ❑ adoptive parents ❑ other relative ❑ other
2. Does your child have any siblings? ❑ Yes ❑ No; if yes, how many? _____
3. Do you have any pets? ❑ Yes ❑ No
4. Do you have moisture problems in your home? ❑ Yes ❑ No
5. Do you have smoke and carbon monoxide detectors in your home? ❑ Yes ❑ No
6. Is your child passively exposed to smoke? ❑ Yes ❑ No
7. Are there any guns present in your home? ❑ Yes ❑ No

Lifestyle:

1. Does your child wear a helmet when biking? ❑ Yes ❑ No
2. Does your child use a seat belt or car seat routinely? ❑ Yes ❑ No

Marriage and Sexuality:

1. Parents' marital status: ❑ married ❑ unmarried ❑ divorced ❑ separated ❑ other

Diet and Exercise:

1. What type of diet is your child following? ❑ Regular ❑ Vegetarian ❑ Vegan ❑ Gluten free ❑ Specific ❑ Carbohydrate ❑ Cardiac ❑ Diabetic
2. What is your child's exercise level? ❑ None ❑ Occasional ❑ Moderate ❑ Heavy
3. How many days of moderate to strenuous exercise, like a brisk walk, did your child do in the last 7 days? _____
4. What types of sporting activities does your child participate in? _____

General Pediatric:

1. Is your child currently in school? ❑ Yes ❑ No; if yes, what is the name of the school? Current grade? _____
2. What type of child care do you use? ❑ none ❑ relatives ❑ babysitter ❑ daycare/preschool
3. Does your child have any accommodations for medical problems? ❑ Yes ❑ No
4. Has your child had a dental visit in the past 12 months? ❑ Yes ❑ No; Date of last visit: _____

ALLERGIES:

List anything your child is allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

CHILD'S PAST MEDICAL HISTORY:

Check any medical problems your child has been treated for or diagnosed with (if needed, explain):

√	Diagnosis	Please explain	√	Diagnosis	Please explain
	Digestive Disorder			Recurrent otitis media	
	Endocrine Disorder			Reproductive disorder	
	Immunologic Disorder			Respiratory disorder	
	Skin disorders			Skeletal disorder	
	Lymphatic disorders			Urinary disorder	
	Musculoskeletal disease				
	ADD/ADHD			Developmental or behavioral disorders	
	Adverse reaction to vaccines			Headaches	
	Autism Spectrum Disorder			Head injury/ concussion	
	Blood disease or bleeding disorders			Depression/anxiety/ mental illness	
	Chicken pox			Seizures/ epilepsy	
	Congenital anomalies			Other: _____	

CURRENT MEDICATIONS: Please list all the medications your child is taking. Include any prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Medication name	Dosage and frequency	Condition being treated

PREFERRED PHARMACY: _____

SURGICAL HISTORY:

Has your child had any of the following surgeries or procedures?

√	Surgery	Date	√	Surgery	Date
	Circumcision			Tonsillectomy	
	Frenotomy			Adenoidectomy	
	Ear tubes (tympanostomy)			Hernia repair	
	Eye muscle surgery (strabismus surgery)			Other: _____	

BIOLOGICAL FAMILY MEDICAL HISTORY:

Do any family members have any of the following conditions? (Please specify which family member; ex. father, mother, brother, sister, maternal or paternal grandfather/grandmother, etc.)

RELATION	SIGNIFICANT HEALTH PROBLEMS
Father	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Mother	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Brother/sister	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Brother/sister	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Grandmother (maternal)	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Grandfather (maternal)	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Grandmother (paternal)	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Grandmother (paternal)	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____

(ONLY) FOR PATIENTS 13 AND OLDER:

1. Do you or have you ever smoked tobacco? ❑ Yes ❑ No
    a. If YES: how many years have you smoked? _____
    b. At what age did you start smoking tobacco? _____
    c. How much tobacco do you smoke? ____ packs per day/ week
2. Do you or have you ever used any other forms of tobacco or nicotine? ❑ Yes ❑ No
    a. IF YES: Do you or have you ever used e-cigarettes or vape? ❑ never used ❑ former user ❑ current user
    b. Do you or have you ever used smokeless tobacco (ex. snuff, chew tobacco)? ❑ never ❑ former user ❑ current user
3. What is your level of alcohol consumption? ❑ none ❑ occasional ❑ moderate ❑ heavy
4. Do you use any illicit or recreational drugs? ❑ Yes ❑ No
    a. IF YES: which illicit or recreational drugs have you used? _____
5. What is your level of caffeine consumption? ❑ none ❑ occasional ❑ moderate ❑ heavy
6. Are you sexually active? ❑ Yes ❑ No
    a. IF YES: do you use protection during sex? ❑ always ❑ usually ❑ no