Cardinal Pediatrics, PLLC

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Social Security #: _____ Sex: _____ Age: _____

Race: _____ Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Biological Child ☐ Adopted Child ☐ Foster Child ☐ Other: _____

RESPONSIBLE PARTY

Name: _____
Relationship: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
SSN: _____
Date of Birth: _____
Person has: Physical Custody Y / N
Medical Custody Y / N
Educational Custody Y / N

Name: _____
Relationship: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
SSN: _____
Date of Birth:_____
Person has: Physical Custody Y / N
Medical Custody Y / N
Educational Custody Y / N

*Law Decree may be requested if custodial issues exist

INSURANCE INFORMATION

Primary Insurance

Carrier: _____
Subscriber: _____
Subscriber DOB: _____
ID / Group #: _____

Secondary Insurance

Carrier: _____
Subscriber: _____
Subscriber DOB: _____
ID / Group #: _____

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider, Cardinal Pediatrics, PLLC, when he/she accepts assignment.

Authorization to Release Medical Information: I hereby authorize my Provider, Cardinal Pediatrics, PLLC, to release any information necessary for my course of treatment.

Patient Responsibility: I accept responsibility for claims not paid by my insurance.

Signature: _____ Date: _____
(Parent or Legal Guardian if minor child)

Cardinal Pediatrics

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment, Healthcare operations, and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

A Copy of our Notice of Privacy Practices is available upon request.

Signature: _____ Date: _____
(Parent or Legal Guardian if minor child)

Printed name: _____
(Parent or Legal Guardian if minor child)

Relationship to Patient: _____

CONTACT INFORMATION

(circle) Yes / No If we are unable to reach you, may Cardinal Pediatrics contact you via text, Patient Portal messages, or leave voicemails with the following of type of information:

- Negative Lab Results
- Appointment Reminders
- Appointment information for referrals
- Billing information requests
- Reminders for outstanding account balances

Only the following information can be relayed:

_____

_____

_____

Cardinal Pediatrics

Patient Name: _____ Date of Birth: _____

Caregiver completing form: _____ Date: _____

Specific Concerns w/ descriptions:

Speech delay: _____

Motor delay: _____

Behavior issues: _____

Other: _____

When did concerns begin: _____

Previous Medical Diagnoses: _____
(i.e. seizures, developmental delay) _

Previous testing / dates related to concerns:

- MRIs/CT scan: _____
- EEG: _____
- Sleep study: _____
- Other: _____
- Genetic Testing: _____
- Developmental Testing: _____
- Autism Specific Testing:_____
- Hearing Evaluation: _____

Current Medications (prescription or over the counter) - include name/dosage and frequency:

_____

_____

_____

Early Intervention/ Therapy Services - include services, location and beginning and ending dates:

- Birth to Three: _____
- Speech Therapy: _____
- Occupational Therapy: _____
- Physical Therapy: _____
- ABA Therapy: _____
- Other: _____

Primary Language used in home: _____ Interpreter needed for visit: YES / NO

Name of school or daycare: _____

Please list Special Accommodations, IEP or 504? _____

_____

_____

Cardinal Pediatrics

Patient Name: _____ Date of Birth: _____

PREGNANCY HISTORY

Maternal Age _____ Paternal Age _____ Number Pregnancy of this patient _____

Prev Miscarriages/Abortions _____

Problems during pregnancy: ☐ High blood pressure ☐ Gestational Diabetes ☐ Pre-eclampsia

☐ Other:_____

Medication use during pregnancy (Rx or OTC): _____

Drug/Alcohol use (incl substance and how often): _____

Delivery type ☐ Vaginal ☐ Scheduled C-Section ☐ Emergency C-Section Delivered at _____ weeks

Complications during Delivery: _____

Problems after delivery: ☐ Jaundice ☐ Trouble Breathing ☐ NICU Stay

☐ Other: _____

Birth Weight: _____ Length of Hospital Stay: _____

DEVELOPMENTAL HISTORY

When did patient start walking independently: _____

First word / Age: _____ How many words in current vocabulary: _____

Does child say 2+ words together to make a sentence: YES / NO

Can child follow simple verbal commands (i.e. bring me the blanket, go get your cup): YES / NO

Current concerns about motor skills: _____

Any vision concerns: _____

Any hearing concerns: _____

Has child ever lost any developmental skills (include skills/age): _____

_____

Previous Surgeries or Overnight hospitalizations: _____

_____

FAMILY HISTORY – please list relation: parent, siblings/half sibling, aunts/uncle, cousin, grandparent

YES / NO Developmental Delays: _____

YES / NO Learning Problems: _____

YES / NO Intellectual disability/Mental retardation: _____

YES / NO Seizures/epilepsy: _____

YES / NO Birth Defects: _____

(e.g. spina bifida, brain malformation, cleft palate/lip, club feet)

YES / NO Autism: _____

YES / NO Genetic Syndrome / Abnormal genetic test result: _____

YES / NO Bone or muscle problems: _____

Other significant medical history: _____

Cardinal Pediatrics

Patient Name: _____ Date of Birth: _____

Concerns about child's behavior from caregivers or teachers:

- ☐ Aggression
- ☐ Self injurious behaviors
- ☐ Decreased interest in others
- ☐ Unusual interests or obsessions
- ☐ Trouble with changes in routine
- ☐ Poor focus
- ☐ Impulsive/ hyperactive behaviors
- ☐ Repetitive body movements (hand flapping/toe walking)
- ☐ Lack of Safety Awareness
- ☐ Sensory Issues
- ☐ Other: _____

_____

Any other specific concerns the family would like to discuss at the visit (i.e. sleep, potty training, feeding issues: _____

_____

Referred by: _____

In addition to the this completed form, please provide us the following information:

- **Medical records**
- **Immunization Records**
- If child attends school, please include:
  - **School Records**: IEP, 504 or Special Accommodation
  - Ask teacher to complete the **Teacher/Caregiver Questionnaire** – found online at www.cardinalpediatrics.com under Forms and Screeners

To send information:

- Securely email at www.cardinalpediatrics.com/securesend
- Fax to 304-599-8003
- Mail to 1247 Suncrest Towne Centre, Morgantown, WV 26505

To plan for your upcoming visit – check out our Autism page at www.cardinalpediatrics.com. It provides information on what to expect and available resources.