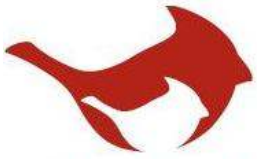


Cardinal Pediatrics, PLLC

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, PLLC

Patient Authorization to Release Protected Health Information to Third Parties

Patient Name: _____Date of Birth: _____

Authorization: I authorize Cardinal Pediatrics, PLLC to (1) disclose the above listed patient's PHI and (2) treat the above listed patient and disclose PHI when brought to the office by:

- Please include the Full Name of any family member (mother/father, grandparents, step-parents, etc) or Group organization (school, daycare) that may request access to the patients' medical records.

Name	Relationship	Phone Number*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Phone number will be used to verify person's identity when calling office for PHI requests

Scope of Authority: I authorize Cardinal Pediatrics, PLLC to disclose the above listed patient's PHI as follows (check only one):

☐ All PHI that the above named entities may request. If applicable, this information may include information pertaining to chronic disease, behavior health conditions, communicable disease, including HIV/AIDS, and/or genetic information.

_____ Also include any alcohol and substance abuse records, if applicable (indicate by initialing)

☐ Disclose ONLY the following PHI to the above name entity:

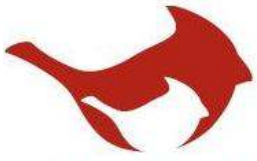
_____

_____

I understand that I may revoke this consent at any time, in writing, except where information has already been released. This authorization is valid until the patient reaches 18 years of age.

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

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



Cardinal Pediatrics, PLLC

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, PLLC

Health History Form

Name: _____ Date of Birth: _____

Pregnancy & Birth History	Previous Pregnancies #: _____ Miscarriages #: _____ Stillbirth #: _____ Mother's Health During Pregnancy: ☐ Excellent ☐ Illness/Complications (Describe)
	Delivery: ☐ Vaginal ☐ C-Section Delivered at _____ Weeks

Family History	Family Health: Conditions such as asthma, seasonal allergies, seizures, cancers, diabetes, congenital defects, mental retardation, thyroid problems etc. Mom: Dad: Siblings: Maternal Grandmother: Maternal Grandfather: Paternal Grandmother: Paternal Grandfather: Aunts, Uncles, Cousins:

Medical History	Does your child have any medical conditions? (Include any significant past medical history including Chicken pox, meningitis, whooping cough, etc) Has your child had any surgeries? When and Where and any complications? Has your child ever been Hospitalized? When and Why? Current Medications: Medication Allergies:

Allergies	Please describe any allergies the child may have:

Cardinal Pediatrics, PLLC

Name: _____ Date of Birth: _____

Developmental History

	Month	Not Known		Yes	No
Able to Sit			Sleeplessness		
Able to Walk alone			Temper Tantrums		
Understanding what is said			Overactive		
Getting along with Children his own age			Clumsy		
Speech: 1st Words					
Speech: Putting words together					

Nutritional History

Breast Fed? ☐ Yes ☐ No Number of Months _____

Bottle Fed? ☐ Yes ☐ No Age Started? _____ Formula? _____ Age Stopped? _____

Solids: Age Introduced? _____ Variety? _____ Allergies? _____

Vitamins: Age Introduced? _____ Variety? _____ Allergies? _____

Current Care

Is child now being seen at a clinic or by a physician? ☐ Yes ☐ No
Is yes, give reason: _____
When last seen: _____
Name and address of clinic or physician providing care: _____
_____
Current Medications:

Social Information

Who lives in the house?

Do you live in a house, townhouse, apartment, trailer?

City water or well water?

Pets:

Does anyone smoke (including those who go outside to smoke)?

Immunization Records

Please bring your shot record to the visit. Many school and day care forms require shot record information. Doctor's offices have up to 1 month to send the child's chart, so sometimes this information isn't available at the time of the visit.

Cardinal Pediatrics, PLLC

Authorization for Release of Medical Record Information

Patient Name: _____Date of Birth: _____

Address: _____

Phone Number: _____

I hereby authorize: (Please list previous physician name, address, etc.)

Name:_____

Address: _____

Phone: _____ Fax: _____

to disclose information for my/my minor child's medical record to:

Cardinal Pediatrics, PLLC
1247 Suncrest Towne Centre
Morgantown, WV 26505
phone # 304 599-8000
fax # 304 599-8003

For the purpose of: ☐ Continuation of medical care ☐ payment of bill ☐ education ☐ legal purpose
☐ at the request of the patient/patient's representative for personal access, or
☐ other: _____

The specific information I wish to have released is: ☐ **Entire Medical Record**

☐ Clinic notes	☐ Consultations	☐ History & Physical	☐ Immunizations
☐ Discharge Summary	☐ Itemized Bills	☐ Laboratory Reports	☐ Medications
☐ Pathology Reports	☐ X-ray Reports	☐ other: _____	

Patient initials	Parent initials	**Separate consent must be given before information related to the following conditions is released.** Please sign your initials before each applicable section.
_____	_____	Evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse, or dependence may be released to the recipient noted on the signed authorization
_____	_____	Patient testing, diagnosis or treatment for HIV/AIDS, venereal disease, or abortion may be released to the recipient noted on the signed authorization
_____	_____	Patient evaluation, testing, diagnosis or treatment concerning mental health /rehabilitation information may be released to the recipient noted on the signed authorization

I understand that I may revoke this consent at any time, in writing, except where information has already been released. This authorization is valid for a 180 day period from the date it is signed.

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

Witness Signature_____Date:_____