

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

*Law Decree may be requested if custodial issues exist

INSURANCE INFORMATION

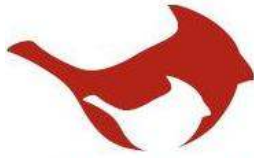
<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Carrier: _____	Carrier: _____
Subscriber: _____	Subscriber: _____
Subscriber DOB: _____	Subscriber DOB: _____
ID / Group #: _____	ID / Group #: _____

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.

<u>Name</u>	<u>Relationship</u>	<u>Phone Number*</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*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.

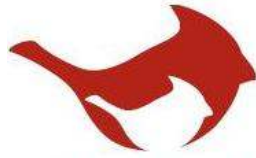
_____ Also include any alcohol and substance abuse records, if applicable (indicate by initialing)

- 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)

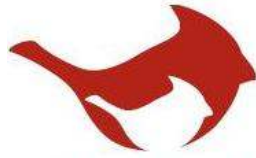
Relationship to Patient: _____

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

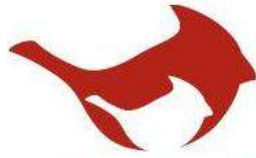
Name: _____ Date of Birth: _____

Pregnancy & Birth History	Previous Pregnancies #: _____ Miscarriages #: _____ Stillbirth #: _____ Mother's Health During Pregnancy: <input type="checkbox"/> Excellent <input type="checkbox"/> Illness/Complications (Describe)
	Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> 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:
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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:
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Allergies	Please describe any allergies the child may have:
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Cardinal Pediatrics, PLLC

Name: _____ Date of Birth: _____

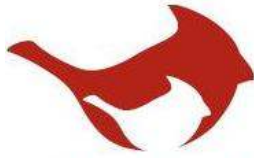
Developmental History		Month	Not Known		Yes	No
	Able to Sit			Sleeplessness		
	Able to Walk alone			Temper Tantrums		
	Understanding what is said			Overactive		
	Getting along with Children his own age			Clumsy		
	Speech: 1 st Words					
	Speech: Putting words together					

Nutritional History	Breast Fed? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of Months _____
	Bottle Fed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.
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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 Parent Separate consent must be given before information related to the following
initials initials 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: _____