

EMERGENCY CONTACT: (Other than Mother or Father)

Name (Last, First, Middle)		Relationship
Home Phone Number	Work Phone Number	Cell Phone Number

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date _____ / _____ / _____

Office Use Only:
General Comment Section:



South Charlotte Primary Care
 Carolinas HealthCare System
Pediatric History

Chart # _____

Patient's Full Name: _____ Patient's Date of Birth: _____

FAMILY HISTORY

Mother's Full Name: _____ Date of Birth: _____

Occupation: _____ Phone #: () _____

Cell #: () _____

Father's Full Name: _____ Date of Birth: _____

Occupation: _____ Phone #: () _____

Cell #: () _____

Parent(s) marital status: Single Married Separated Divorced Widowed
 Your relationship to patient: Mother Father Stepmother Stepfather Grandparent Other

Patient's Siblings:

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Type of Water: City water Well water

Are there smoker's in the patient's household: NO YES who: _____ Does patient attend daycare: NO YES

BIRTH HISTORY

Mother's age at delivery: _____ Patient's Birth Weight: _____ Patient's Birth Length: _____

Type of Delivery: Vaginal C-section Patient born: # Weeks early _____ On time # Weeks late _____

Did patient have any problems: _____

Type of infant feeding: Breast Formula

FAMILY MEDICAL HISTORY

Please indicate which of the patient's family members has the following conditions:

MEDICAL CONDITION	RELATIONSHIP	MEDICAL CONDITION	RELATIONSHIP
<input type="checkbox"/> Diabetes _____		<input type="checkbox"/> Obesity _____	
<input type="checkbox"/> Convulsions _____		<input type="checkbox"/> Migraine Headaches _____	
<input type="checkbox"/> High Blood Pressure _____		<input type="checkbox"/> High Cholesterol _____	
<input type="checkbox"/> Allergies _____		<input type="checkbox"/> Tuberculosis _____	
<input type="checkbox"/> Heart Disease/Stroke Before Age of 60 _____		<input type="checkbox"/> Asthma _____	
<input type="checkbox"/> Cancer _____		<input type="checkbox"/> Alcoholism/Drug Abuse _____	

PATIENT HISTORY

- Has the patient ever had any serious or chronic illness? (e.g.: Asthma, Allergies, Diabetes, Seizures) No Yes

If so, what and when? _____

- Has the patient had any operations or hospitalizations? No Yes

If so, what and when? _____

- Is the patient allergic to any medications, foods, insects, etc? No Yes

If so, what? _____

- Do you have questions or concerns regarding the patient's development? No Yes

If so, what? _____

- Do you have any questions or concerns regarding the patient's behavior? No Yes

If so, what? _____

- Do you have any questions or concerns regarding the patient's school performance? No Yes

If so, what? _____

Parent's Signature: _____ Date: _____