# SUMTER PEDIATRICS, P.A.
# PATIENT INFORMATION
**www.sumterpediatrics.com**

Full Name: ______________________________________________ DOB: ____/______/______ SEX: (M) (F)
(Last) (First) (Middle)

Mailing Address: ______________________________ City: __________________ State _______ Zip Code _______

Contact #: ( ) ____________________ Social Security#:_______-______-________ Race: __________ Language: ______________

**FAMILY**

Person Responsible for Patient (Parent or Legal Guardian):______________________________ Email: ____________________

**Father's Name:** ______________________________ Date of Birth: ______________________________

Mailing Address: ______________________________ City: __________________ State _______ Zip Code _______

Social Security #: ______________________________ Cell Phone #: ______________________________

Place of Employment: ______________________________ Work Telephone #: ______________________________

**Mother's Name:** ______________________________ Date of Birth: ______________________________

Mailing Address: ______________________________ City: __________________ State _______ Zip Code _______

Social Security #: ______________________________ Cell Phone #: ______________________________

Place of Employment: ______________________________ Work Telephone #: ______________________________

**Emergency Contact:** ______________________________ **Telephone #:** ______________________________

**INSURANCE**

Primary Insurance:____________________ Eff. Date __________ Primary Policy Number: ____________________

Policy Holder Name:______________________________ Telephone: ______________________________

Date of Birth: ______________________________ SSN: ______________________________

Secondary Insurance: ____________________ Eff. Date __________ Secondary Policy Number: ____________________

Secondary Policy Holder Name: ______________________________ Telephone: ______________________________

Date of Birth: ______________________________ SSN: ______________________________

**PHARMACY:** ______________________________ **ADDRESS:** ______________________________

**PHONE #:** ______________________

**PARENT/LEGAL GUARDIAN PERMISSION FOR MEDICAL CARE**

I, ______________________________, give ______________________________
(Parent/Guardian) (Relatives, Friends or Babysitter) * Please list all who may apply
____________________ permission to get medical care for my child, ______________________________, at Sumter Pediatrics, P.A. This includes any immunizations and/or other medical procedures that may be necessary.

**CONSENT**

By signing this form, you are granting consent to Sumter Pediatrics, P.A. to use and disclose the protected health information for the purposes of treatment, payment and health care operations for this child. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full and I understand, that my signature on this form states that I have received a copy of the Privacy Policy of Sumter Pediatrics, P.A. for my child.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: Contacting Sumter Pediatrics, P.A. Business Office at 803-775-3813 or visiting www.sumterpediatrics.com.

**AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO SUMTER PEDIATRICS, P.A.**

I hereby authorize the physician designated to release information acquired in the course of my examination and treatment. I hereby assign payment directly to the designated physician for any medical/surgical procedures. I agree that this authorization shall be valid until rescinded in writing.

**AUTHORIZATION FOR REVIEW OF PRESCRIPTION HISTORY**

I authorize Sumter Pediatrics, P.A. to access my electronic records of previously prescribed medications through the external electronic prescribing network, Surescripts.

**CONSENT TO RECEIVE MAIL, PHONE, EMAIL OR TEXT MESSAGES FOR APPOINTMENTS REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS**

I consent to receive voice, email and text messages from the practice at any phone numbers and emails listed, and to any number forwarded or transferred to that number or emails to receive communication. I understand that this request to receive emails and text messages will apply to all future appointment reminders/general health information unless I request a change in writing.

______________________________ ______________________________
(Parent/Guardian) (Date) (Witness) (Date)

## Family History

| | Age | Health | |
|---|---|---|---|
| Mother | | | Miscarriages Month Cause |
| Father | | | Heart Attacks/Strokes |
| Sibling | | | Allergy |
| Sibling | | | Diabetes |
| Sibling | | | Mothers Blood Type Rh Baby's Blood Type |

**PATIENT'S BIRTH/DEVELOPMENT/FEEDING**

Term: Full Early Late Delivery: Normal C-Section Birth Weight:______________

Obstetrician:____________________________________________ Previous Doctor: _______________________

| Gestational Age | Delivery | Weight | Length | HC |
|---|---|---|---|---|
| Complications | | | Apgar Store | |
| Sat Up | Fed Self | Grasps | Words | |
| Breast | Formula | | Vitamins/Iron/Floride | |

Mother's use of (Please check one): ______ Alcohol ______ Tobacco ______ Drugs ______ None

**PATIENT'S HISTORY**

1. Has the patient had any of the following?
   Heart Disease Pertussis Mumps
   Seizures Measles Chicken Pox
   Diabetes Rubella
   Operations, if so what_______________________________________________________________
   Allergic Reactions, if so when ________________________________________________________

2. Has the patient had any of the following?
   Persistent/Productive Cough
   Weight Loss/Gain (other than normal)
   Other____________________________________________________________________________

3. List all the doctors the patient currently sees.
   a. ______________________________________________________________________
   b. ______________________________________________________________________
   c. ______________________________________________________________________
   d. ______________________________________________________________________

4. List all the medications this patient is currently taking.
   a. ______________________________________________________________________
   b. ______________________________________________________________________
   c. ______________________________________________________________________
   d. ______________________________________________________________________

5. Do you have any concerns regarding this patient's growth and/or development? If so, what?
   ______________________________________________________________________________
   ______________________________________________________________________________
   ______________________________________________________________________________

Date ___________________

Patient's Name ____________________________________________ Date of Birth ________________

## MEDICAL INFORMATION

Do you consider your child to be in good health? ☐No ☐ Yes Explain__________________________
Besides birth, has your child ever been hospitalized? ☐No ☐ Yes Explain__________________________
Has your child ever had: A blood transfusion ☐No ☐ Yes Explain__________________________
Convulsions or seizures ☐No ☐ Yes Explain__________________________
Heart problems/murmur ☐No ☐ Yes Explain__________________________
Surgeries ☐No ☐ Yes Explain__________________________
Serious illnesses ☐No ☐ Yes Explain__________________________
Does your child have any: Food Allergies ☐No ☐ Yes Explain__________________________
Drug Allergies ☐No ☐ Yes Explain__________________________
Are you concerned about your child's development: ☐No ☐ Yes Explain__________________________
Physical ☐No ☐ Yes Explain__________________________
Mental ☐No ☐ Yes Explain__________________________
Social/emotional ☐No ☐ Yes Explain __________________________
Are you concerned about your child's attention span? ☐No ☐ Yes Explain__________________________
Girls Only: Has your daughter started her menstrual cycle? ☐No ☐ Yes At what age______________________
Has she experienced problems? ☐No ☐ Yes Explain__________________________

Does your child attend school/day care? ☐No ☐ Yes ☐ Where ____________________________
If so, how is their behavior in school? ☐ Excellent ☐ Average ☐ Not good Explain______________________
How are their grades? ☐ Excellent ☐ Average ☐ Failing Explain______________________
On average, how many hours/day does your child spend in front of a screen*? TV, Computer, Video Game ___________hrs/day*
Do you have concerns about your child's weight? ☐No ☐ Yes Explain__________________________
Does your child routinely exercise or engage in physical activity? ☐No ☐ Yes Explain__________________________
Has your child experienced on going constipation? ☐No ☐ Yes Explain__________________________
Has your child had any unusual feeding/dietary problems? ☐No ☐ Yes Explain__________________________

Has your child experienced any of the following? If yes, please explain below.

| | | | | | |
|---|---|---|---|---|---|
| Frequent ear infections | ☐No ☐ Yes | Wheezing/Asthma | ☐No ☐ Yes | Diabetes | ☐No ☐ Yes |
| Other problems with ears or hearing | ☐No ☐ Yes | Bronchitis/pneumonia | ☐No ☐ Yes | Fevers | ☐No ☐ Yes |
| Chronic or recurrent skin problems | ☐No ☐ Yes | Lung/breathing issues | ☐No ☐ Yes | Headaches | ☐No ☐ Yes |
| Nasal Allergies | ☐No ☐ Yes | Abdominal Pain | ☐No ☐ Yes | Chicken Pox | ☐No ☐ Yes |
| Problems with eyes/vision | ☐No ☐ Yes | Bladder or kidney infections | ☐No ☐ Yes | Bedwetting 5+yrs | ☐No ☐ Yes |

Explain:______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please explain any other medical or social history that you consider important: ____________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**CURRENT MEDICATION (including vitamins, herbs, and over-the-counter)**

| Name | Dose | Name | Dose |
|---|---|---|---|
| ---------------------------- | ---------------------------- | ---------------------------- | --------------------------- |
| ---------------------------- | ---------------------------- | ---------------------------- | --------------------------- |
| ---------------------------- | ---------------------------- | ---------------------------- | --------------------------- |

Has your child seen or consulted specialist or other health care providers? ☐No ☐Yes

If yes, please list: ___________________________________________________________________________

For Office Use Only

______ Reviewed by Office Staff ____________________________________________

Name & Date Reviewed

______ Reviewed by Clinical Staff ____________________________________________

Name & Date Reviewed

Approved _______

Denied _______ Explain: ____________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

____________________________________________________________

Letter sent regarding acceptance or denial _____________________

Date

# Vaccination Policy

Sumter Pediatrics, P.A. makes the health and well-being of our patients, their families, our staff and the surrounding community our top concern. Further, we firmly believe in the effectiveness of proper vaccination to prevent serious illness and to save lives, and in the safety of the vaccines we administer. For these reasons, we require that all of our patients receive vaccinations according to the Recommended Child and Adolescent Immunization Schedule published by the Centers for Disease Control and Prevention (CDC) and endorsed by the Academy of Pediatrics (AAP).

If you have questions or concerns about vaccinations, we will always take the time to discuss them in detail and will make a separate appointment for that purpose if necessary. If you are ultimately unwilling to comply with this policy, we will ask you to transfer your child's care to another provider who is willing to conform to your preferences. We do not keep a list of such providers, nor would we recommend any such physician. Policy reviewed: March 2019

Date: ____________________

Patient Name: ________________________________

Parent/Guardian Name: ________________________

Parent/Guardian Signature: ______________________

_____I Refuse Vaccination for my child________________________Date: ______________

Parent/Guardian Name: ___________________________

Parent/Guardian Signature: ________________________