Blue Springs Family Care, P.C.

104 NW State Route 7, Suite B
Blue Springs, MO 64014
Phone: (816) 229-8880 Fax: (816) 229-4363
www.bluespringsfamilycare.org

NEW PATIENT INFORMATION SHEET - Child

________________ ________________ ______ ________________
Last Name First Name MI Nickname

Gender ☐M ☐F ________-______-__________ Social Security Number ☐ Single ☐ Married ☐ Divorced ☐ Widow _____/______/_________ Date of Birth

Race: ☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other ______________ ☐ Decline to answer

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other ________________

Address where the child lives:

________________ ________________ ________ ________
Address City State Zip

I authorize the release of my medical information to the local HIE (Health Information Exchange) - Yes ☐ No ☐

I authorize the release of my immunization records to the local immunization registry - Yes ☐ No ☐

Responsible Parties:

Primary Contact/Responsible Party: Father / Step-Father / Mother / Step-Mother *(Circle one)*

________________ ________________ ____/_____/________ _______-______-_______
Last Name First Name Date of Birth Social Security Number

Address (If different than above) ____

Primary Phone # ( ) _______-________ Home ☐ Work☐ Cell ☐ Secondary Phone # ( ) _______-________ Home ☐ Work☐ Cell ☐

E-Mail Address ____________________________ E-mail/Patient Portal preferred contact method? Yes ☐ No ☐

May we leave personal health information, including test results, on your answering machine? Yes ☐ No ☐

Secondary Contact/Responsible Party: Father / Step-Father / Mother / Step-Mother *(Circle one)*

________________ ________________ ____/_____/________ _______-______-_______
Last Name First Name Date of Birth Social Security Number

Address (If different than above) ____

Primary Phone # ( ) _______-________ Home ☐ Work☐ Cell ☐ Secondary Phone # ( ) _______-________ Home ☐ Work☐ Cell ☐

May we leave personal health information, including test results, on your answering machine? Yes ☐ No ☐

If we are unable to contact you, may we mail your personal health information to the patient's home address? Yes ☐ No ☐

Whom may we speak with concerning your personal health information? *(In addition to the responsible parties listed above.)*

Name ________________ Phone ________________ Relationship______________

Name ________________ Phone ________________ Relationship______________

Are there any restrictions on what information we can give them? ______________________________

If there are any restrictions to whom can bring child to appointments or have access to medical information, please provide us with that information: ____

John Peterson, DO ▪ Tuongvan Tran, MD
Stefany Hastings, FNP-C ▪ Kathrine Stipanovich, FNP-C ▪ Michelle Cass FNP-C ▪ Amy Jensen, FNP-C

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Insurance Information

Primary Insurance Company ______________________________ Claims Phone # (   ) _______-_________

Office Visit Co-Pay $_____________ Effective Date ____________

Policy/ID # ________________________ Group # _______________

Claims Address ____

Policy Holder's Information: Check here if ☐ *Mother or* ☐ *Father listed on 1st page is policy holder and skip this section*

Last Name __________________ First Name ____________________ Date of Birth _______________

Relationship to Patient _______________ Gender M/F Social Security # ______________________

Policy Holder's Address (If different from patient)____

Phone (   ) _______-_________ Employer ______________________ Work Phone (   ) _______-_________

Secondary Insurance Company ______________________________ Claims Phone # (   ) _______-_________

Office Visit Co-Pay $_____________ Effective Date ____________

Policy/ID # ________________________ Group # _______________

Claims Address ____

Policy Holder's Information: Check here if ☐ *Mother or* ☐ *Father listed on 1st page is policy holder and skip this section*

Last Name __________________ First Name ____________________ Date of Birth _______________

Relationship to Patient _______________ Gender M/F Social Security # ______________________

Policy Holder's Address (If different from patient)____

Phone (   ) _______-_________ Employer ______________________ Work Phone (   ) _______-_________

AUTHORIZATION AND CONSENT

I request that all payment of authorized Medicare/Insurance benefits on my behalf be paid to Blue Springs Family Care, P.C. for all services rendered to me. I authorize any holder of medical information about me be released to the Centers for Medicare and Medicaid Services or any insurance company listed above or their agents in order to determine any benefits payable for related services. I authorize the release of health information as discussed in the privacy policies made available to me by BSFC.

I authorize Blue Springs Family Care, P.C. to access my medication history and formulary information through a secure electronic connection.

I understand that services for which I am treated may or may not be covered by my insurance company and/or Medicare. I am aware that I can be billed and am responsible for any existing or remaining dollar balance after all mandatory adjustments have been made to my account.

The privacy policies of BSFC have been made available to me for my review.

BSFC gladly accepts your check as payment. However, in an effort not to inconvenience you in the unlikely event that these funds are dishonored, we reserve the right to collect them electronically for the face value of the check, plus any applicable fees as permitted by state law.

Please note, children under 16 years of age must be accompanied by a parent or guardian. Information regarding children over 18, pregnant, having a child or married will not be released to the parent unless patient indicates otherwise. Also patient information regarding sexual activities, drug or alcohol abuse and mental health will not be released unless otherwise indicated.

Parent or Guardian Signature____ Date _______________

Printed Name ________________________________ Relationship to patient ____________________________

Patient Name ____ Date of Birth _____/_____/________

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HEALTH HISTORY

Name ____________________ Today's Date ____________

Age __________ Birthdate ____________ Date of last physical examination ______________

What is your reason for visit? ______________________________

Symptoms – List symptoms you currently have or have had in the past year. ____________________

____

____

Females Only: ***(if applicable)***

Date of last menstrual period ____________
Date of last Pap Smear ____________
Are you pregnant? ☐ Yes ☐ No

Conditions – Check conditions you have had in the past

☐Aids	☐Cataracts	☐High Cholesterol	☐Psychiatric Care
☐Alcoholism	☐Chemical Dependency	☐HIV Positive	☐Rheumatic Fever
☐Anemia	☐Chicken Pox	☐Kidney Disease	☐Seizure Disorder
☐Anorexia	☐Depression	☐Liver Disease	☐STDs (Sexually Transmitted Diseases)
☐Anxiety	☐Diabetes	☐Migraine Headaches	☐Stroke
☐Appendicitis	☐Emphysema	☐Miscarriage	☐Stomach Ulcers
☐Arthritis	☐Glaucoma	☐Mononucleosis	☐Suicide Attempt
☐Asthma	☐Gonorrhea	☐Multiple Sclerosis	☐Thyroid Problems
☐Bleeding Disorders	☐Gout	☐Mumps	☐Tuberculosis
☐Breast Lump	☐Heart Disease	☐Pacemaker	☐UTI (Frequent Urinary Tract Infections)
☐Bronchitis	☐Hepatitis	☐Pneumonia	
☐Bulimia	☐Hernia	☐Polio	
☐Cancer	☐Herpes	☐Prostate Problem	

IMMUNIZATIONS – If disease, put "D" and year. ☐ *Immunization record provided* *(do not need to fill out this section)*

Last year given	Last year given	Last year given
Tetanus ____________	Pneumonia ____________	Influenza ____________
MMR ____________	Pertussis ____________	Chicken Pox ____________

☐ Immunization record requested

Medications – List medications you are currently taking

Name ____________ Dose __________ Name ____________ Dose __________
Name ____________ Dose __________ Name ____________ Dose __________
Name ____________ Dose __________ Name ____________ Dose __________

Allergies – List all allergies to Medications or Substances and your reaction to these

____________________ ____________________

____________________ ____________________

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Health Habits – Check which substances you use and describe how much you use.

☐Caffeine ______________ ☐Drugs _____________ ☐Tobacco _______________ ☐Other ___________

Hospitalizations / Surgical History / Serious Illness / Injuries / Pregnancies

Year	Condition	Outcome	If Hospitalized – Hospital Name

FAMILY HISTORY – Fill in health information about your family. If unknown please write in "Unknown"

Relation	Age/year born	State of Health	Age at Death	Cause of Death	Diseases
Father					
Mother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Brothers					
Sisters					

Check if your blood relatives had any of the following diseases (this includes all aunts and uncles):

Relationship to you	Relationship to you
☐ Arthritis, Gout ______________________________	☐ Heart Disease, Strokes _________________________
☐ Asthma, Hay Fever __________________________	☐ High Blood Pressure __________________________
☐ Cancer/ Location ___________________________	☐ Kidney Disease______________________________
☐ Chemical Dependency _______________________	☐ Tuberculosis _____________________________
☐ Diabetes _________________________________	☐ Other _____________________________

Parent or Guardian Signature____ Date ________________

Printed Name __________________________________ Relationship to patient _____________________________

Patient Name _________________________ Date of Birth ______/______/_________

For Office Use Only:

☐ Physician reviewed Date _________________________ Initials _______________________