



**NEW PATIENT INFORMATION SHEET - Child**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Nickname \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender M F \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  Single  Married  
Date of Birth Social Security Number  Divorced  Widowed

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
( ) \_\_\_\_\_-\_\_\_\_\_ ( ) \_\_\_\_\_-\_\_\_\_\_ ( ) \_\_\_\_\_-\_\_\_\_\_ \_\_\_\_\_  
Home Phone Cell Phone Office Phone Ext.

Preferred Language:  English  Spanish  Vietnamese  Other \_\_\_\_\_

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

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:**

Father / Step-Father (Circle one)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Address (If different than above) \_\_\_\_\_  
( ) \_\_\_\_\_-\_\_\_\_\_ ( ) \_\_\_\_\_-\_\_\_\_\_ ( ) \_\_\_\_\_-\_\_\_\_\_  
Home Phone Work Phone Ext Cell Phone

Mother / Step-Mother (Circle one)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Address (If different than above) \_\_\_\_\_  
( ) \_\_\_\_\_-\_\_\_\_\_ ( ) \_\_\_\_\_-\_\_\_\_\_ ( ) \_\_\_\_\_-\_\_\_\_\_  
Home Phone Work Phone Ext Cell Phone

**In order to get your health information to you as quickly as possible and in a manner you request – please fill in the following information.**

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 your home address? Yes  No

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

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: \_\_\_\_\_



**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 1<sup>st</sup> 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 1<sup>st</sup> 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 \_\_\_\_/\_\_\_\_/\_\_\_\_



**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

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

**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 _____
<input type="checkbox"/> 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

\_\_\_\_\_

\_\_\_\_\_



**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	
<input type="checkbox"/> Arthritis, Gout _____	<input type="checkbox"/> Heart Disease, Strokes _____	<input type="checkbox"/> Asthma, Hay Fever _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cancer/ Location _____	<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Chemical Dependency _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Other _____		

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Office Use Only:**

Physician reviewed Date \_\_\_\_\_ Initials \_\_\_\_\_