REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: ______________________________ DOB____/____/__________

I hereby request that any communication made by Gales Ferry Pediatrics to me be made:

____Home phone/ work phone ______answering machine _______mail

_________Address _______other

May we speak with?

_______Parents ________children ________other family members ________other

I give permission for the information to be left on my answering machine:

______Test results _______appointments with other doctors ________appointment for tests

______Reminder calls for appointments _______information regarding prescriptions ______other

I would like all future communications to me to be made in accordance with my wishes as expressed above. I understand that if I refuse to specify an alternate address or to provide information as to how payment, if any, will be handled Gales Ferry Pediatrics may deny my request.

Signature of Patient or Personal
Representative:____

Relationship to Patient: ______________________________ Date_____/______/__________

WRITTEN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ hereby acknowledge that I have received a copy of the Notice of Privacy Practice. I understand that if I have further questions or complaints I may contact: Dorene Harold, Practice Administrator: 860-464-7248 x12

I also understand that I am entitled to receive updates upon request if Gales Ferry Pediatrics Notice of Privacy Practices is amended or changed in a material way.

____ /______/__________

Signature Date

____

Relationship to Patient

TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On_____/_____/__________, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

___ Patient declined to sign this Written Acknowledgement

___ Patient did not understand the request to sign the Written Acknowledgement

___ Other- specify: ____

Name and title of
Employee______________________________________ Date_____/_____/________

PATIENT MEDICAL HISTORY SHEET

PATIENTS NAME: ______________________________ **DOB:** ____/____/________

BIRTH Name of Hospital ____________________ City & State ________________

(please circle)

Pregnancy: Normal/ Complicated, if so how? ____________________

Labor: Normal/ Complicated, if so how? ____________________

Delivery: Normal/ Complicated, if so how? ____________________

Gestation: Full Term/ Pre-term/ Post mature

NEWBORN Birth Weight: ________ lbs. ________ oz Birth Length ________ inches

Nursery Complication (circle and explain)- Jaundice Respiratory Distress Feeding Problems Other:

PAST HISTORY DATE REASON

Hospitalization:

Surgery:

Trauma: (such as concussion, fractures, etc.)

Medical Specialist seen: (such as allergist, etc.)

Recurrent Chronic Illnesses (please list)

1. ____________ 2. ____________ 3. ____________

Allergies

1. ____________ 2. ____________ 3. ____________

Serious Illnesses in last year:

1. ____________ 2. ____________ 3. ____________

Date of Last Physical Exam: ____________ *Abnormalities* ____________

FAMILY HISTORY:

Mothers Name: ______________________ Age: ______ Height ______

Fathers Name: ______________________ Age: ______ Height ______

Marital Status ______ Married ______ Separated ______ Divorced ______ Widowed

Years date date date

If separated or divorced:

A. Amount of contact your child has with non care-taking parent ____________

B. Do you feel your child has problems resulting from separation? If so, what type?

C. Is there another father/mother figure in the house? How does the child relate to him/her?

Brothers ______ how many ______ ages? Sisters ______ how many? ______ Ages?

Grandparents, Parents, Aunts or Uncles of Child had any of the Following: (please circle)

Allergies Arthritis (juvenile) Asthma Bleeding Disorders Cancer-type? ____________

Congenital Eye Disease Congenital Heart Disease Cystic Fibrosis Epilepsy Diabetes Glaucoma

Heart Disease High Blood Pressure Kidney Disease Mental Retardation Sickle Cell Stroke T.B Thyroid Disease

SOCIAL HISTORY:

Living: ______ House ______ Mobile Home ______ Apartment #of years ______ # Of household members

Water supply: ______ City ______ Well ______ Spring

In Case of Emergency Contact:

Name: ______________________ phone# ____-____-____

Address ______________________ - ____________, ______. ____________

City St. Zip Code

PROBLEMS AND

CONCERNS ____________________