WESTSIDE PEDIATRIC GROUP, LLP
497 Beahan Road
Rochester NY 14624
PH (585) 247 5400
Fax (585) 319 4124

MICHAEL D. GREEN, M.D.
CAROL A. GAGNON, M.D.
GRETCHEN R. VOLK, M.D.
MOLLY E. HUGHES, M.D.
COLETTE K. BARCZYS, M.D.

PATIENT INFORMATION SHEET

TODAY'S DATE _____/_____/_____

PATIENT_____ _____ _____ _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SEX_____ PHONE_____CELL/LANDLINE

MAILING ADDRESS _____

CITY _____ STATE_____ZIP _____

PROVIDE ANY CURRENT CUSTODY ORDERS (IF APPLICABLE)

RACE/ETHNICITY SELECT ALL THAT APPLY

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Decline
- ☐ Hispanic/Latin/Spanish Origin

PATIENT **PRIMARILY** LIVES WITH:

- ☐ BOTH PARENTS
- ☐ MOTHER
- ☐ FATHER
- ☐ GUARDIAN
- ☐ GRANDPARENT
- ☐ FOSTER PARENT

PREFERRED LANGUAGE:

IS A TRANSLATOR REQUIRED? YES / NO

HIPAA (PRIVACY NOTICE):
OTHER AUTHORIZED ALTERNATE CONTACTS, LISTED BELOW (*STEP-PARENT, GRAND PARENT, AUNT, UNCLE*).
MOTHER AND FATHER ARE AUTOMATICALLY CONSIDERED AUTHORIZED FOR ANYONE UNDER THE AGE OF 18.

NAME _____ RELATIONSHIP_____ PHONE_____

ADDRESS_____CITY_____ ZIP_____

NAME _____ RELATIONSHIP_____ PHONE_____

ADDRESS_____CITY_____ ZIP_____

NAME _____ RELATIONSHIP_____ PHONE_____

ADDRESS_____ CITY_____ ZIP_____

	APPOINTMENT INFORMATION	**MEDICAL INFORMATION**
MAY WE LEAVE A MESSAGE ON HOME PHONE? (Including auto call)	YES / NO	YES / NO
MAY WE LEAVE A MESSAGE ON CELL PHONE? (Including auto call)	YES / NO	YES / NO
MAY WE SEND TEXT MESSAGES ON CELL PHONE? (Including auto call)	YES / NO	YES / NO
MAY WE LEAVE A MESSAGE ON OFFICE VOICE?	YES / NO	YES / NO
MAY WE LEAVE A MESSAGE WITH ANOTHER PERSON	YES / NO	YES / NO
SEND INFORMATION VIA REGULAR MAIL?	YES / NO	YES / NO
SEND INFORMATION VIA E-MAIL/PATIENT PORTAL?	YES / NO	YES / NO

MOTHER/LEGAL GUARDIAN'S INFORMATION

NAME _____ _____ _____ _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ RACE _____ PHONE_____CELL/LANDLINE

ALTERNATE PHONE_____WORK/OTHER

MAILING ADDRESS(if different than patient)_____

CITY _____ STATE _____ZIP _____

EMPLOYER_____

EMAIL (to be web enabled)_____

FATHER/LEGAL GUARDIAN'S INFORMATION

NAME_____ _____ _____ _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ RACE_____ PHONE_____CELL/LANDLINE

ALTERNATE PHONE_____WORK/OTHER

MAILING ADDRESS (if different than patient) _____

CITY _____ STATE _____ZIP _____

EMAIL _____

EMPLOYER _____

MANY OF OUR FAMILIES ARE EXPERIENCING DIFFICULTY IN THE FOLLOWING AREAS, PLEASE CHECK OFF ANY OF THE AREAS YOU WOULD LIKE TO SPEAK WITH SOMEONE ABOUT ANY OF THESE ISSUES:

___FOOD INSECURITY ___HOUSING PROBLEMS ___TRANSPORTATION ISSUES ___CONCERNS WITH HEALTH INSURANCE

ELECTRONIC SIGNATURES WILL BE CAPTURED AT THE TIME OF YOUR CHILD'S OFFICE APPOINTMENT, VERIFYING THE INFORMATION ABOVE AND THE STATEMENTS BELOW.

INSURANCE-AUTHORIZATION TO PAY BENEFITS: THIS IS AN AGREEMENT TO BE SIGNED AT THE TIME SERVICES ARE RENDERED. IF YOUR INSURANCE IS NOT VALID OR THE SERIVCE/IMMUNZATION IS DENIED OR NOT COVERED BY YOUR ISURANCE YOU WILL BE CHARGED AS A PRIVATE PAY PATIENT AS PER OUR FINANCIAL AGREEMENT, WHICH IS AVAILABLE TO YOU IN THE WAITING AREA.

PAYMENT AGREEMENT: WESTSIDE PEDIATRICS WILL USE ANY/ALL PHONE NUMBERS LISTED TO CONTACT YOU IN REGARD TO ACCOUNT BALANCES, INCLUDING CELL PHONE NUMBERS.

INSURANCE-RELEASE: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS, AND THE RELEASE OF THE INFORMATION BAK TO MY PHYSICIAN. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE STATED PHYSICIAN(S) FOR SERVICES RENDERED.

PRIVACY POLICY: I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE PRACTICE'S PRIVACY NOTICE AND IF I SO CHOOSE, A COPY WILL BE GIVEN TO ME. (Copies are available in the waiting areas and on our website.)

UPDATED 9/5/2018

Initial History Questionnaire

_____ _____ _____

Patient Name | Form Completed by /Relationship to patient | Date Completed

Household

Please list all adults and children living in the child's home.

Name	Relationship to Child	Birth Date	Notes
			Are there any adults or siblings not listed? If so, please list their names, date of birth, relationship to the child and where they live.

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illnesses or problems with her pregnancy?

❑ Yes ❑ No Explain _____

During pregnancy, did mother:

Smoke ❑ Yes ❑ No Drink Alcohol ❑ Yes ❑ No

Use drugs or medications ❑ Yes ❑ No

What _____ When _____

Was the delivery ❑ Vaginal ❑Caesarean

If Caesarean, why? _____

Did your baby have any problems right after birth?

❑ Yes ❑ No Explain

_____

Was initial feeding ❑ Breast ❑ Bottle

Did your baby go home with mother from the hospital?

❑ Yes ❑ No Explain

_____

General

Has your child had any broken bones, serious injuries, concussion?	❑ Yes ❑ No Explain:	
Does your child have any serious illness or medical condition?	❑ Yes ❑ No Explain:	
Has your child had any Emergency Room visits?	❑ Yes ❑ No Explain:	
Has your child had any operations or been hospitalized?	❑ Yes ❑ No Explain:	
Does your child take any medications or supplements?	❑ Yes ❑ No Explain:	
Is your child allergic to any medicines, foods, bee stings, cats/dogs?	❑ Yes ❑ No Explain:	

Development

Are you concerned about your child's physical development?	❑ Yes ❑ No Explain:	
Are you concerned about your child's mental or emotional development?	❑ Yes ❑ No Explain:	
Are you concerned about your child's attention span?	❑ Yes ❑ No Explain:	

If your child is in school:

How is his/her behavior in school? _____

Are you concerned about your child's school performance?_____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in a special or resource classes? _____

WESTSIDE PEDIATRIC GROUP, LLP

Family History

Did/Do you or any of the child's relatives have any of the following? (If YES, please identify relative)	Mother	Father	Siblings	Father's Parents	Mother's Parents
Allergies					
Asthma/Wheezing					
Cardiac (heart) problems					
Fainting					
Sudden Death (before age 60)					
Stroke/Blood Clots					
High cholesterol					
High Blood Pressure					
Diabetes					
Obesity					
Bleeding Tendency					
Cancer (Please specify type)					
Scoliosis					
Dev Hip Dysplasia					
Eczema or Psoriasis					
Arthritis					
Thyroid					
Stomach or Intestinal problems					
Kidney/Renal disease					
Migraines					
Seizures					
Hearing Loss					
Vision problems					
Mental retardation					
Developmental delays					
Autism					
Sleep Disorder					
School problem					
Learning disability					
ADHD					
Depression					
Anxiety or OCD					
Bipolar disorder/psychiatric problems					
Alcoholism, drug use/addiction					
Genetic (cystic fibrosis, hemophilia, Marfan syndrome, Leiden V mutation, neurofibromatosis etc.					
Birth Defects					
Reaction to dyes or anesthesia					
Chemical exposure (military or job related)					
Immune problems, HIV or AIDS					

Any additional medical problems that run in the family: _____

_____

_____

Home type: House Apartment Mobile Home

Heating: Forced Air Hot Water/Radiator Wood/Pellet Stove Other

Drinking Water: Village Well Bottled

Flouride in drinking water? Yes No Unsure

Does your child spend time in a home built before 1970 or one recently remodeled ? Yes No

Are there guns in the Home ? Yes No If Yes how are they stored_____

Any Pets? Yes No If Yes please list_____

Any cigarette smokers? Yes No If yes please list_____

Are you experiencing any family or financial problems? Yes/No _____

Child's History

Does your child have, or has he/she ever had:

Chickenpox	❑ Yes	❑ No	When
Frequent ear infections	❑ Yes	❑ No	Explain
Problems with ears or hearing	❑ Yes	❑ No	Explain
Nasal allergies	❑ Yes	❑ No	Explain
Problems with eyes or vision	❑ Yes	❑ No	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	❑ Yes	❑ No	Explain
Any heart problem or heart murmur	❑ Yes	❑ No	Explain
Anemia or bleeding problem	❑ Yes	❑ No	Explain
Blood transfusion	❑ Yes	❑ No	Explain
Frequent abdominal pain	❑ Yes	❑ No	Explain
Constipation requiring doctor's visits	❑ Yes	❑ No	Explain
Bladder / kidney infection	❑ Yes	❑ No	Explain
Bed-wetting (after 5years old)	❑ Yes	❑ No	Explain
(For girls) Has she started her menstrual periods?	❑ Yes	❑ No	Explain
(For girls) Are there problems with her period?	❑ Yes	❑ No	Explain
Any chronic or recurrent skin problem	❑ Yes	❑ No	Explain
(acne, eczema, etc.)			Explain
Frequent headaches	❑ Yes	❑ No	Explain
Convulsions or other neurological problem	❑ Yes	❑ No	Explain
Diabetes	❑ Yes	❑ No	Explain
Thyroid or other endocrine problem	❑ Yes	❑ No	Explain
Any other significant problem	❑ Yes	❑ No	Explain
Use of alcohol or drugs	❑ Yes	❑ No	Explain