Pediatric New Patient Intake Form

Please refer to our website, www.MilestonePediatrics.org, for a list of accepted insurances.

Patient Information **Date:** _____

Last Name: _____ First Name: _____ DOB: _____

Home Phone: _____ Mobile Phone: _____ Preferred: ☐ Home ☐ Cell

Primary Pediatrician: _____ Phone: _____

Pediatrician's Address: _____

Referring Provider: _____ Phone: _____

Referring Provider's Address: _____

Preferred Pharmacy: _____ Phone: _____

Preferred Pharmacy's Address: _____

Parent 1's Name: _____ Phone: _____ E-mail: _____

Address: _____

Occupation: _____ Spouse/Partner: _____

Parent 2's Name: _____ Phone: _____ E-mail: _____

Address: _____

Occupation: _____ Spouse/Partner: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
☐ Decline Response
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race:
☐ Decline Response
☐ American-Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White

Preferred Language: _____ ☐ Decline Response ☐ Other

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Milestone Pediatrics, LLC (d/b/a Patti's Place) for services rendered. I authorize representatives of Patti's Place to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the Milestone Pediatrics Notice of Privacy.

☐ Received ☐ N/A (only if you received the Notice from Milestone Pediatrics previously)

Patient Portal Sign Up – Milestone Pediatrics

Look for an invitation from Milestone Pediatrics to access your child's personal records securely, 24/7, on a computer, smartphone, or tablet at (preferred E-mail address): _____ ☐ Opt-out

Insurance Plan Information Disclosure and Consent

You will be provided with information regarding the health plans that Milestone Pediatrics accepts. If Milestone Pediatrics does not accept your health plan, you will be asked to sign a consent form stating that you agree to accept treatment.

I read and agree to all of the above (Financial Obligation Agreement, Notice of Privacy, Patient Portal Sign Up, Insurance Plan Information).

Parent or Legal Guardian Name (Print): _____

Parent or Legal Guardian Signature: _____ Date: _____

Last Name: _____ First Name: _____ DOB: _____

Medical and Social History

Reason for today's visit: _____

_____

Is the patient adopted? ☐ Yes ☐ No (If "Yes", please answer the following to the best of your knowledge.)

Birth weight: _____ Weeks' of gestation at birth: _____ Delivery: ☐ C-Section ☐ Vaginal Delivery

If C-Section, why? _____

Please Describe any health problems the mother or patient experienced during pregnancy or after birth,any: _____

_____

Patient's current weight: _____ Patient's height: _____

Immunization Record

Vaccine	Description	Date / Dates*	Vaccine	Description	Date / Dates*
☐ HepB	Hepatitis B		☐ Flu	Influenza	
☐ DTap	Diphtheria, Tetanus, Acellular Pertussis		☐ MMR	Measles, Mumps, Rubella (German Measles)	
☐ Hib	Haemophilus Influenzae Type B		☐ HepA	Hepatitis A	
☐ IPV	Inactivated Poliovirus		☐ →	Varicella (Chickenpox)	
☐ PCV	Pneumococcal Conjugate		☐ HPV	Human Papillomavirus	
☐ RV	Rotavirus		☐ →	COVID-19	

*If multiples doses are needed.

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? ☐ Yes ☐ No

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL current medications, including over-the-counter supplements and herbs:

Medication Name	Dose	Medication Name	Dose

Please list any past surgeries and hospitalizations and the approximate date.

Procedure/Hospitalization	Date	Reason	Complications

Last Name: _____ First Name: _____ DOB: _____

Medical and Social History (Continued)

Has the patient EVER had any of the following?

Anemia/Bleeding tendency	☐ Yes ☐ No		Ear/Nose/Throat	☐ Yes ☐ No
Asthma/Breathing problems	☐ Yes ☐ No		Eczema/Skin disorder	☐ Yes ☐ No
Behavioral problems	☐ Yes ☐ No		Eye disorder	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No		Growth disorder	☐ Yes ☐ No
Bowel/Stomach problems	☐ Yes ☐ No		Heart disorder/defect	☐ Yes ☐ No
Cancer/Leukemia	☐ Yes ☐ No		Kidney/Bladder problems	☐ Yes ☐ No
Chickenpox/Shingles	☐ Yes ☐ No		Liver disease	☐ Yes ☐ No
Developmental disorder	☐ Yes ☐ No		Seizure or Epilepsy	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No		Thyroid disorcer	☐ Yes ☐ No

Please list any other medical illnesses or problems and provide details for any of the above conditions: _____

Does your child use a wheelchair? ☐ Yes ☐ No

Does your child have a tracheostomy? ☐ Yes ☐ No Percentage of Oxygen? _____

Does your child have an endotracheal (breathing) tube? ☐ Yes ☐ No Is your child on a ventilator? ☐ Yes ☐ No

Family History: Please indicate any major conditions/illnesses that the patient's immediate family members have had.

Relative	Condition(s) and Description	Living?	If deceased, at what age?
Parent 1		☐ Yes ☐ No	
Parent 2		☐ Yes ☐ No	
Sibling		☐ Yes ☐ No	
Other		☐ Yes ☐ No	

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to Patient

Last Name: _____ First Name: _____ DOB: _____

Medical and Social History (Continued)

Patient Social History

Does anyone who lives in your home smoke? ☐ Yes ☐ No If yes, how many cigarettes or packs per day? _____

Do you have any pets? ☐ Yes ☐ No If yes, how many? _____ What type(s): _____

For females only: Have you started menstruating? ☐ Yes ☐ No If yes, at what age did you start? _____

Review of Systems

Please indicate (check) ALL that the patient has experienced within the past 6 to 12 months:

Constitutional

☐ Fever	☐ Fatigue	☐ Weight Gain (_____ Lbs.)	☐ Sleep Disturbances
☐ Chills	☐ Sweats	☐ Weight Loss (_____ Lbs.)	☐ Other
		☐ Unexplained Weight Change	

Head, eyes, Ears, Nose, and Throat

☐ Vision Problem(s)	☐ Neck Stiffness	☐ Dry Mouth	☐ Other
☐ Decreased Hearing	☐ Nosebleed	☐ Sore Throat	
☐ Red Eyes	☐ Congestion	☐ Hoarseness	
☐ Runny Nose	☐ Snoring	☐ Earache	

Cardiovascular

☐ Chest Pain	☐ Cold Extremities	☐ Irregular Heart Rythm	☐ Other
☐ Palpitations	☐ Cold Hands or Feet		

Respiratory

☐ Shortness of Breath	☐ Rapid Breathing	☐ Chest Congestion	☐ Other
☐ Cough	☐ Wheezing		

Gastrointestinal

☐ Abdominal Pain	☐ Constipation	☐ Yellow Skin	☐ Heartburn
☐ Blood in Stool	☐ Diarrhea	☐ Trouble Swallowing	☐ Other
☐ Vomiting	☐ Black/Tarry Stools	☐ Vomiting Blood	
☐ Nausea	☐ Decreased Appetite	☐ Bowel Incontinence	

Neurological

☐ Headache	☐ Confusion	☐ Seizures	☐ Poor Coordination
☐ Dizziness	☐ Numbness	☐ Fainting (Syncope)	☐ Unsteady
☐ Decreased Strength	☐ Tingling	☐ Jitteriness	☐ Other

Musculoskeletal

☐ Joint Pain	☐ Limb Pain	☐ Muscle Pain	☐ Other
☐ Neck Pain	☐ Joint Swelling	☐ Muscle Weakness	
☐ Back Pain	☐ Muscle Cramps	☐ Leg Swelling	

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Medical and Social History (Continued)

Review of Systems (Continued)

Genitourinary

☐ Frequent Urination	☐ Urinary Urgency	☐ Pelvic Pain	☐ Other
☐ Incontinence	☐ Painful Urination	☐ Irregular Menstrual Cycle	

Integumentary (Skin, Hair, Nails, Glands)

☐ Rash	☐ Skin Wound	☐ Itching	☐ Other
☐ Dry Skin	☐ Unusual Growth	☐ Skin Cancer	

Psychiatric

☐ Depression	☐ Anxiety	☐ Other

Hematologic/Lymphatic

☐ Easy Bruising	☐ Easy Bleeding	☐ Swollen Lymph Nodes	☐ Other

Endocrine

☐ Excessive Thirst	☐ Heat Intolerance	☐ Changes to Skin	☐ Other
☐ Cold Intolerance	☐ Changes to Hair		

FOR OFFICE USE ONLY:

Provider Signature: _____ Date: _____