**THREE-FIVE YEAR HEALTH QUESTIONNAIRE**

**Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person filling out form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VACCINE HISTORY**

**Up to Date \_\_\_ Yes \_\_\_ No Please provide a copy of his/her vaccine record.**

**Delayed Schedule: \_\_\_\_**

**PROBLEM LIST**

**Please put a check next to the problem and fill in the year diagnosed. If child does NOT have any of these problems, check NONE.**

**( ) Allergies \_\_\_\_\_\_\_ ( ) Eczema \_\_\_\_\_\_ ( ) Ear Infections \_\_\_\_\_\_**

**( ) Asthma \_\_\_\_\_\_\_ ( ) GERD \_\_\_\_\_\_ ( ) Developmental Delay \_\_\_\_\_**

**( ) ADD/ADHD \_\_\_\_\_\_\_ ( ) Seizures \_\_\_\_\_\_ ( ) NONE**

**( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGICAL HISTORY**

**Please list all surgeries your child has had and give the year of that surgery.**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**Hospitalizations**

**Please list any hospitalizations your child has had, the reason, and the date.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**CURRENT MEDICATIONS**

**Please list any and all medications or pills that child is presently taking regularly or from time to time. If none, please state “none”.**

**Drug Name/Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICATION ALLERGIES**

**If child is allergic to any medication(s), please list them. Give Name of medication and type of reaction (Rash, Shock, Respiratory problems, GI upset, Unknown, Other). If none, please state “none”.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HISTORY**

**Father**

**List any health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**No Known Health Problems  Has Died – Age and Cause of Death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother**

**List any health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**No Known Health Problems Has Died – Age and Cause of Death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brothers**

**How many \_\_\_\_\_\_\_ No Known Health Problems List any health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has Died – Age and Cause of Death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sisters**

**How many \_\_\_\_\_\_\_ No Known Health Problems List any health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has Died – Age and Cause of Death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

**Birthplace: (State/Country) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Household members: Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother(s ) \_\_\_\_\_ Sister(s ) \_\_\_\_\_**

**Others living in home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Smoking in the home? \_\_\_\_ Yes \_\_\_\_ No**

**Firearms in the home? \_\_\_\_ Yes \_\_\_\_ No Gun Locks \_\_ Y \_\_ N Pets in home \_\_Y \_\_N**

**History of physical/sexual abuse \_\_\_ Yes \_\_\_ No Explain \_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Potty Trained \_\_\_ Yes \_\_\_ No Bowel Movements \_\_\_\_\_ Is the child in daycare \_\_\_ Yes \_\_\_ No**

**DEVELOPMENTAL HISTORY:**

**Do you have concerns about your child meeting developmental milestones\_\_\_\_Yes \_\_\_\_ No**

 **(examples: walking, talking, skipping, eating with utensils, reading, etc.)**

**Any concern about hearing or vision \_\_\_Yes \_\_\_No**

**Has child been held back in school \_\_\_ Yes \_\_\_ No Grade: \_\_\_\_\_\_\_\_**

**Is child in special classes at school \_\_\_ Yes \_\_\_No Subject: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BIRTH HISTORY**

**Delivery: ( ) Vaginal ( ) Cesarean (C-section) Reason for C-Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Weight: \_\_\_\_\_\_\_\_\_ Length: \_\_\_\_\_\_\_\_**

**Was the baby born within 2 weeks from the due date \_\_\_ Yes \_\_\_ No**

**Did the baby have to stay in the hospital for an extended time \_\_\_ Yes \_\_\_ No**

**DIETARY HISTORY**

**Servings per day**

**( ) Dairy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) Fruits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) Vegetables \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) Meats \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) Please list what your child drinks daily \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EDUCATION LEVEL: School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade level: \_\_\_\_\_\_\_\_**

**Please list concerns and/or questions you would like to discuss during today’s visit.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Cole Family Practice, LLC - Registration Form**

**Patient Information**

First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male Female

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Marital Status: M S D W SS#:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Information**:

Patients Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent or Financially Responsible Party (if different than patient)**

First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male Female

Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance**

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardholders Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_ Cardholders Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Present Insurance Cards and Picture ID at Reception Desk**

**OFFICE POLICY**

I authorize Cole Family Practice, LLC to furnish information to insurance carriers concerning my care. I agree to pay Cole Family Practice, LLC for all services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

**SELF-PAY PATIENTS** will be required to pay for your office visit before you are seen. However, you are responsible for any additional cost related to the visit. Federal Law requires that we bill every patient the same amount. We are not allowed to change billing based on whether or not patients have insurance.

**INSURANCE PATIENTS** – IT IS YOUR RESPONSBILITY TO:

* Provide a Credit Card/Debit card for authorization.
* Provide us with updated and current insurance information at each visit.
* Provide us with updated contact information including phone numbers and address.
* Pay your deductible and/or copay at the time of service
* Pay for any services not covered by your insurance
* Make sure you have a current referral if your insurance requires one.

As a courtesy to our patients we will file all claims with your insurance carrier and provide them with any information necessary to process the claim.

**YOU ARE RESPONSBILE FOR ALL SERVICES RENDERED – IF (FOR ANY REASON) YOUR INSURANCE DOES NOT PAY- THE BALANCE IS YOUR RESPONSIBILITY.**

All patients are required to present a credit card/debit card at the time of service that we will authorize for payment of services rendered. Your credit card/debit card will only be charged for your co-pay and/or deductible at the time of service. Once we receive an EOB from your insurance company, we will bill your card for the remaining amount you owe up to the amount you authorized at the time of service. If the amount you authorized does not cover the total amount due, we will then send you a statement.

**The charges will never be more than the amount you authorized at the time of service. If the amount you authorized does not cover the amount due, a statement will be mailed to you for the remaining amount.**

If the insurance company denies your claim, stating you are not eligible or your coverage has terminated, your credit card/debit card that was authorized at the time of service will be charged for the authorized amount. If you have new insurance, we will file your claim to your new insurance company. However, no refunds will be issued until payment is received by the insurance company.

Unpaid Bills – A collection agency will be chosen to manage delinquent accounts. Once referred to collections, no assistance will be provided by our office. If your account is placed with a collection agency, you will be responsible for all collections and attorneys fees necessary to collect this debt.

**CONSENT TO TREAT & MEDICAL RECORDS RELEASE AUTHORIZATION:**

I authorize Cole Family Practice practitioners to provide treatment that they may deem advisable for my dependants and me. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment. I authorize Cole Family Practice to conduct urine drug screens as part of my assessment per the office policy. I authorize Cole Family Practice to obtain any previous medical records, for my dependants or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependants or me.

**I have read and understand the above items regarding insurance, finance, responsibility, authorization of charges, consent, and medical records and agree to the terms and conditions related to each item.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Responsible Party Signature Date**

**Cole Family Practice, LLC – HIPAA/Permission From**

The Health Insurance Portability and Accountability Act (HIPPA) require Cole Family Practice to notify patients regarding how their Protected Health Information is handled. Our HIPPA policy is posted in the Lobby. You have the right to review policy and take a copy of the policy. With your permission, we may disclose your Protected Health Information to a family member, close friend ,or any other person that you identify.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Cole Family Practice to

release any personal information relating to my health care.

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the HIPPA Notice of Privacy Practices for Cole Family Practice. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_