

Pediatric Health History Form

Welcome — it is our privilege to serve as your child's health care provider. We believe that the best care begins with truly understanding them as a whole person. **An honest and complete health**

history helps us deliver safe, personalized care tailored just for them. Everything you share will

remain confidential and will be used only to help us provide the best care possible. Thank you for trusting us with their health — we are honored to be part of their care journey. *Please fill out every question to the best of your ability, taking your best guess if unsure.*



Name: _____ Sex: M F Date of Birth: ____ / ____ / ____ Date Completed: ____ / ____ / ____

Family Information: *Provide information about adults involved in child's life, including those they live with.*

Mother's Full Name	Father's Full Name
Step-Mother's Full Name (if applicable)	Step-Father's Full Name (if applicable)
Custodial Provider's Full Name (if other than above)	Relationship to Patient

Marital status of parents: ☐ Single parent ☐ Married ☐ Partner/Civil Union ☐ Separated ☐ Divorced ☐ Widowed

The child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Mother/Partner ☐ Father/Partner ☐ Grandparent/Other

Other Children in child's family/home? *Indicate if they live with the child.*

Birth Date	Gender	Name	Lives with?	Birth Date	Gender	Name	Lives with?
	M F		Y N		M F		Y N
	M F		Y N		M F		Y N
	M F		Y N		M F		Y N

Is there any tobacco/vape use by those who are caregivers to the child? ☐ Y ☐ N Who?: _____

Are there any cultural or religious practices that might affect your child's medical care? ☐ Y ☐ N

Explain: _____

Family Medical History: *Does family (parents, siblings, grandparents, aunts/uncles) have any of the following? If there is more than one condition listed, please circle all those that apply in that section.*

Condition	Relationship	Condition	Relationship
ADHD / Learning Disability	☐ N ☐ Y _____	Cancer	☐ N ☐ Y _____
Autism Spectrum Disorder	☐ N ☐ Y _____	Type: _____	
Anxiety / Depression / Mental Health Disorder	☐ N ☐ Y _____	Immune Disorders (low immunity, frequent infections)	☐ N ☐ Y _____
Developmental Delay / Intellectual Disabilities	☐ N ☐ Y _____	Diabetes (Type 1 or 2)	☐ N ☐ Y _____
Seizure Disorder / Epilepsy	☐ N ☐ Y _____	Thyroid / Hormone Disorders	☐ N ☐ Y _____
Migraines / Frequent Headaches	☐ N ☐ Y _____	Growth Concerns / Metabolic Disorders	☐ N ☐ Y _____
Cerebral Palsy / Neuromuscular Disorder	☐ N ☐ Y _____	Kidney Disease / Malformation	☐ N ☐ Y _____
Congenital / Structural Heart Problems	☐ N ☐ Y _____	Recurrent Urinary Tract Infections	☐ N ☐ Y _____
Heart Disease	☐ N ☐ Y _____	Liver Disease / Hepatitis / Other Liver Disorder	☐ N ☐ Y _____
High Blood Pressure / Heart Disease	☐ N ☐ Y _____	Bowel / Gastrointestinal Disorders	☐ N ☐ Y _____
High Cholesterol (hyperlipidemia)	☐ N ☐ Y _____	Bone Disorders / Scoliosis / Brittle Bones	☐ N ☐ Y _____
Stoke / Vascular Problems	☐ N ☐ Y _____	Arthritis / Autoimmune Disorders	☐ N ☐ Y _____
Asthma	☐ N ☐ Y _____	Allergies (drug, food, environmental)	☐ N ☐ Y _____
Anemia / Blood Disorder (ie. Sickle cell, clotting)	☐ N ☐ Y _____	Substance Abuse	☐ N ☐ Y _____
		Other: _____	☐ N ☐ Y _____

Prenatal History: *Provide the following information about the time during the mother's pregnancy.*

Was a fertility treatment used? ☐ N ☐ Y Type/Doctor? _____

Were medications or herbs taken? ☐ N ☐ Y Type ? _____

Did mother use any tobacco, alcohol or drugs? ☐ N ☐ Y Type/Amount/Frequency? _____

Did mother experience any of the following?

Bleeding, spotting	☐ N ☐ Y	High blood pressure	☐ N ☐ Y	Kidney disease	☐ N ☐ Y	Threatened miscarriage	☐ N ☐ Y
Gestational diabetes	☐ N ☐ Y	Illness (not cold/flu)	☐ N ☐ Y	Premature labor	☐ N ☐ Y	Pre-eclampsia	☐ N ☐ Y

Birth History: *Provide the following information about your child's birth. If (?) then circle correct choice.*

Birth Weight	lbs	oz	Hospital?	Born: Early?	Late?	How many weeks?
Birth Height	in		City?	Were there any complications for: Mom? Baby?		
APGAR @ 1 min		Delivery:	Vaginal?	Spontaneous?	Explain above:	
		Forceps?	Breech?	Cesarean?		
APGAR @ 5 min		Reason for C-section?			Mother's Age/Preg #	/

During the hospital stay for delivery did the child have any of the following?

Antibiotics	☐ N ☐ Y	Convulsions	☐ N ☐ Y	Skin rash	☐ N ☐ Y	Blue spells	☐ N ☐ Y	German Measles	☐ N ☐ Y
Jaundice	☐ N ☐ Y	Stayed longer in hospital than mother?		☐ N ☐ Y	Reason?				

What was the initial feeding? ☐ Breast Milk ☐ Formula, Reason: _____

Current and Past Medical History: *Has your child experienced any of the following:*

	Explain		Explain
Serious or Chronic Illness	☐ N ☐ Y	Ingested a Poison	☐ N ☐ Y
Serious Injuries or Accidents	☐ N ☐ Y	Allergic Reactions to Immunizations	☐ N ☐ Y
Surgeries	☐ N ☐ Y	Hospitalizations	☐ N ☐ Y

Does your child have or has your child ever had any of the following?

	Explain		Explain
Asthma, reoccurring cough, bronchitis, pneumonia	☐ N ☐ Y	Bladder/kidney problems or bedwetting	☐ N ☐ Y
Nasal Allergies or eczema	☐ N ☐ Y	Any heart problems / murmur	☐ N ☐ Y
Frequent ear infections or sore throats	☐ N ☐ Y	Anemia or bleeding problem	☐ N ☐ Y
Problems with ears or hearing	☐ N ☐ Y	Thyroid or other gland problems	☐ N ☐ Y
Problems with eyes, vision, or teeth	☐ N ☐ Y	Diabetes	☐ N ☐ Y
Frequency headaches or other neurological disorders	☐ N ☐ Y	ADHD/Learning Disability	☐ N ☐ Y
Frequent abdominal pain	☐ N ☐ Y	Mental Health Issues	☐ N ☐ Y
Constipation requiring doctor visits	☐ N ☐ Y	Other	☐ N ☐ Y

Current Medications: *Is your child currently taking any medications, vitamins or herbs?*

Medication	Strength / Dose	Frequency	Medication	Strength / Dose	Frequency
Ex: Amoxicillin	400 mg/5mL, 3.5 mL	2x daily			

Allergies: ☐ No Known Allergies ☐ Allergies to medications/food/other (list and describe reaction)

Medications/Rxn	Food/Rxn	Other
		☐ Seasonal and Environmental



New Patient Registration

PATIENT INFORMATION

Name (Last, First, MI): _____ DOB: _____ Sex (M/F): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Phone: _____ SSN#: _____

Marital Status (Circle One): Married Divorced Single Widow Ethnicity: _____

Race: _____ E-Mail: _____ Pharmacy: _____

How may we contact you with test results or follow up appointments? (Please Circle): Phone Mail Patient Portal

How did you hear about us (Circle): Radio TV Newspaper Friend Physician Referral Internet Other

Employer's Name: _____ Phone Number: _____

_____ Zip: _____

In case of emergency contact: _____ Relationship: _____

Phone: _____ Phone: _____

RESPONSIBLE PARTY (If other than patient)

Name (Last, First, MI): _____ DOB: _____ Sex (M/F): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Phone: _____ SSN#: _____

Marital Status (Circle One): Married Divorced Single Widow Ethnicity: _____

Race: _____ E-Mail: _____ Relationship to Patient: _____

Employer's Name: _____ Phone Number: _____

INSURED'S INFORMATION

Primary Ins Co: _____ Secondary Ins Co: _____

Name (Last, First, MI): _____ DOB: _____ Sex (M/F): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Phone: _____ SSN#: _____

E-Mail: _____ Employer's Name: _____

→ PLEASE SIGN THE LINE BELOW ←

Signature of Patient or Patient Representative _____

Date _____



**AUTHORIZATION OF TREATMENT/
ASSIGNMENT OF BENEFITS/RELEASE OF
INFORMATION/PRIVACY NOTICE**

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Bowling Green Medical Group (BGMG), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made to anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for BGMG on or after 11/30/18.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the BGMG provider of service(s) furnished to me. I authorize BGMG to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to BGMG, I hereby authorize that photocopies of this form and others to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through BGMG medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a BGMG billing statement whether it is an interim or final bill. In the event, that I fail to make full payment or fail to comply with other payment arrangements made with BGMG's approval, I understand that appropriate collection measures may be initiated and discharge from the practice could result.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. BGMG has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant government and regulatory standards. Patient care summaries are automatically sent to designated BGMG and other community primary care/family/referring physicians, as well as, to physicians who are consulted by the attending physician for coordination of care. BGMG and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies for the medical record.

ELECTRONIC PRESCRIBING: I understand that BGMG medical practices and office may use an electronic prescription system which allows prescriptions and related information to be electronically sent between BGMG providers and my pharmacy. I have been informed and understand the BGMG providers using the electronic prescribing system will be able to see information about my medications I am already taking, including those prescribed by other providers. I give my consent to my BGMG providers to see this health information.

IMMUNIZATION REGISTRY: I understand that BGMG participates in the Missouri Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for BGMG to send or fax childhood immunization records to schools, upon request.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all BGMG medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release BGMG from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to an BGMG medical practice, office or facility.

I, or my legal representative, certify that I have read this document, that is has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested. By signing below, I acknowledge that I have received a copy of my patient rights.

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Date of Signing



HIPAA Privacy and Release of Information Authorization

I, the undersigned patient or patient representative, hereby authorize the Bowling Green Medical Group (BGMG) and its affiliates, its employees and agents, to use and disclose protected health information (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified herein may be subject to re-disclosure by such persons/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to BGMG. However, this authorization may not be revoked if its employees or agents have taken action on the authorization prior to receiving my written notice. I also understand that I have a right to a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of the practices: Privacy Practices, Release of Billing Information Policy, Assignment of Benefits Policy and grant the practice Medication History Authority.

If applicable, legal representatives, by signing this form I represent that I am the legal representative of the member identified below and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the members behalf with respect to the authorization form.

Date

Patient, Parent or Legal Guardian Signature

I authorize the following person(s) to obtain my health information by verbal or written communication from BGMG.
I understand that if I do not list anyone, no one but myself may be spoken to regarding my health.

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number



Appointment Cancellation/No-Show Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our providers and staff want to be available for your needs and for the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

Circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. As of June 10th, 2019, there will be a fee of \$60.00 assessed if we do not receive a call to cancel an appointment. You will be given one (1) warning before fees are assessed. If you are more than 15 minutes late to an appointment, it will need to be rescheduled to a different date/time.

After a warning and four (4) missed visits you will be discharged from this clinic.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

The Staff of Bowling Green Medical Group

Patient/Parent Guarding Signature

Date



MEDICAL RECORDS REQUEST/AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I authorize the use of disclosure of my health information as described below. I understand this authorization is voluntary. I understand if the organization authorized to receive the information is not a health plan or health care provider, the release of information may no longer be protected by federal privacy regulations.

Date of Request: _____

Name of Patient: _____ DOB: _____

I HEREBY AUTHORIZE BOWLING GREEN MEDICAL GROUP, LLC LOCATED AT:

905 Hwy 161, Bowling Green MO 63334 Phone: (573) 324-3333 Fax: (833) 996-3335 TO:

_____ Release To: _____ Obtain From: _____

(Provider, Hospital, Medical Clinic, etc)

Information to be released:

- Inpatient, Admit/Discharge Date(s) _____
- Outpatient/Emergency Date(s) _____
- Physician Clinic Date(s) _____
- Other _____

**ATTN PROVIDERS:
PLEASE NO DISCS
THANK YOU!**

Patient information is needed for:

____ Continuing Medical Care
____ Legal Use
____ School

____ Military
____ Insurance
____ Social Security/Disability

I understand the information to be released may include but is not limited to: History, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS I understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. I understand that I may be charged for copies of my medical records. I understand that if I refuse to disclose all or some healthcare information this may result in improper diagnosis or treatment, denial of coverage or claim for health benefits or other insurance, or other adverse consequences. I understand I may have a copy of this release form upon request.

Signature of Patient or Patient's Representative

Date

**PLEASE SIGN THIS DOCUMENT ONLY, OUR OFFICE STAFF WILL COMPLETE THE REST
WE WILL KEEP ON FILE UP TO ONE YEAR FOR FUTURE MEDICAL RECORDS REQUESTS
(Hospitalization, ER, Urgent Care, etc.)**