

PEDIATRIC SPECIALISTS OF BLOOMFIELD HILLS, P.C.

PATIENT INFORMATION

DATE: \_\_\_\_\_ HOME PHONE# \_\_\_\_\_

NAME OF PATIENT: (MINOR CHILD) \_\_\_\_\_ NICKNAME: \_\_\_\_\_

SEX: M F BIRTHDATE: \_\_\_\_\_ PARENT EMAIL ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PERSON FINANCIALLY RESPONSIBLE FOR PATIENT:

FATHER/GUARDIAN NAME: \_\_\_\_\_ MOTHER/GUARDIAN NAME: \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM PATIENT) \_\_\_\_\_ ADDRESS (IF DIFFERENT FROM PATIENT) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SS# \_\_\_\_\_ SS# \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

INSURANCE PLAN NAME: \_\_\_\_\_ INSURANCE PLAN NAME: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ COPAY AMOUNT: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_ COPAY AMOUNT: \_\_\_\_\_

INSURANCE COMPANY PHONE #: \_\_\_\_\_ INSURANCE COMPANY PHONE #: \_\_\_\_\_

DO YOU HAVE COVERAGE FOR MINOR CHILD? \_\_\_\_\_ DO YOU HAVE COVERAGE FOR MINOR CHILD? \_\_\_\_\_

YES NO YES NO

EMERGENCY CONTACT (OTHER THAN PARENT):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU?:

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MINOR CHILD'S STATUS. I CERTIFY THAT MY CHILD IS COVERED BY THE ABOVE NAMED INSURANCE AND ASSIGN DIRECTLY TO THE DOCTOR'S AT PEDIATRIC SPECIALISTS OF BLOOMFIELD HILLS ALL INSURANCE BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

# Pediatric Specialists of Bloomfield Hills, P.C.

Kim R. Coleman, M.D.

Christa A. Shilling, M.D.

43097 Woodward Ave, Suite 201

Bloomfield Hills, MI 48302

In our quest to maintain your personal health information as confidential as possible and to meet the federal guidelines under HIPAA regulations, we have implemented the following authorizations.

Please read and initial each statement:

\_\_\_\_\_ I authorize the use of my child's personal health information to carry out treatment, payment or health care operation.

\_\_\_\_\_ I authorize the use of my child's personal health information in order to obtain medical reports from other physicians or hospitals (e.g. laboratory reports, consultation, outpatient procedures).

\_\_\_\_\_ I authorize the use of my child's personal health information in order to have prescriptions phoned, faxed or electronically transmitted to my pharmacy as needed for the treatment of my child.

I understand that:

I may revoke consent for the above in writing at any time, except to the extent that Pediatric Specialists of Bloomfield Hill, P.C. has taken action in reliance on the consent.

I may request restrictions on the uses or disclosures of health information for the treatment, payment or health care operations.

I may request to review Pediatric Specialists of Bloomfield Hills, P.C.'s Privacy Practice Policy prior to signing this consent.

I have read and understand all of the above statements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FAMILY SAFETY CHECKLIST**

	<b>YES</b>	<b>NO</b>
1. Our family buckles up on every car ride.	<input type="checkbox"/>	<input type="checkbox"/>
2. Our family wears bike helmets when bicycling.	<input type="checkbox"/>	<input type="checkbox"/>
3. Kids under 10 never cross streets alone.	<input type="checkbox"/>	<input type="checkbox"/>
4. Kids are always supervised in or near water.	<input type="checkbox"/>	<input type="checkbox"/>
5. Our home has working smoke and CO detectors.	<input type="checkbox"/>	<input type="checkbox"/>
6. Our water heaters are set no higher than 120° to prevent scald burns.	<input type="checkbox"/>	<input type="checkbox"/>
7. If guns are in our home, they are kept unloaded and locked away.	<input type="checkbox"/>	<input type="checkbox"/>
8. Kids are protected against falls from windows, stairs, furniture and playground equipment.	<input type="checkbox"/>	<input type="checkbox"/>
9. Household cleaners, medicines and vitamins are stored out of young kids' reach.	<input type="checkbox"/>	<input type="checkbox"/>
1. Our home has emergency numbers near telephone and first aid supplies.	<input type="checkbox"/>	<input type="checkbox"/>

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Parent Signature

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Date

# NEW PATIENT MEDICAL INFORMATION

Pediatric Specialists of Bloomfield Hills, P.C.

## PATIENTS NAME

D.O.B.

### A. HEALTH CARE STATUS

1. Where has your child gone for check ups until now? \_\_\_\_\_
2. What is the date of your child's last checkup? \_\_\_\_\_
3. What is the date of your child's last dental checkup? \_\_\_\_\_
4. Is your child under treatment now for an illness or Medical condition? Yes No  
If yes, for what? \_\_\_\_\_  
With whom? \_\_\_\_\_
5. Has your child had allergic reactions to any medications food or bee stings? Yes No
6. Has your child had reactions to any immunizations? Yes No  
If yes, please list: \_\_\_\_\_
7. Any hospitalizations other than birth? \_\_\_\_\_  
If yes, please list: \_\_\_\_\_
8. Does your child take any medications regularly, including over the counter medications such as Tylenol or vitamins? Yes No  
If yes, please list: \_\_\_\_\_

### B. PREGNANCY AND BIRTH

1. Mothers are at birth of this child \_\_\_\_\_
2. Did mother have any illnesses during this pregnancy? Yes No
3. Did mother use any medications other than vitamins/iron? Yes No
4. Was the baby born on time? Yes No
5. What was the baby's birth weight? \_\_\_\_\_
6. Did the baby have any trouble starting to breath? Yes No
7. Did the baby have any trouble in the hospital? Yes No  
If yes, please list: \_\_\_\_\_

### C. FAMILY HISTORY

1. Are the child's parent in good health? Yes No
2. Circle any diseases that this child's parents, grandparents Brothers, sisters, aunts and uncles have had: Anemia Asthma Allergies Diabetes AIDS High Blood Pressure Heart Trouble Tuberculosis Mental Illness Cancer Drug Problem Alcohol Problem Inherited Illness Other \_\_\_\_\_
3. List general health, age and sex of brothers and sisters \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Have any of your children died? Yes No

### D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding Problems during the first 3 months of life? Yes No
4. Do any goods disagree with your child? Yes No
5. Is/was your child **Breast** or **Bottle Fed** or **Both**? (circle)
6. If still on formula which one do you use? \_\_\_\_\_
7. Does your child take vitamins? Yes No

### E. REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? Yes No
2. Has your child had any eye or vision problems? Yes No
3. Has your child had any problems with teeth? Yes No
4. Does your child have frequent colds or sore throats? Yes No
5. Is there asthma, pneumonia or recurrent cough? Yes No
6. Does your child have a heart murmur or any heart problems? Yes No
7. Any problems with urination? Yes No
8. Any problems with diarrhea or constipation? Yes No
9. Have there been any convulsions or other problems with the nervous system? Yes No
10. Any eczema, hives or other skin conditions? Yes No
11. Has your child ever been anemic? Yes No
12. Please list any other medical problems \_\_\_\_\_  
\_\_\_\_\_

### F. DEVELOPMENT / BEHAVIORS

1. At what age did your child sit alone? \_\_\_\_\_
2. At what age did your child walk alone? \_\_\_\_\_
3. Did your child say any words by the time he/she was 1 1/2 years old? Yes No
4. How does your child compare to other children of his or her age? \_\_\_\_\_
5. Does your child have trouble sleeping? Yes No
6. What grade is your child in? Yes No
7. Does your child get along with other children? Yes No
8. Circle if your child has any of the following: Nail Biting Thumb Sucking Bed Wetting Problems with Toilet Training Bad Temper Hyperactivity Nightmares Speech Problems Problems with Discipline Other \_\_\_\_\_  
\_\_\_\_\_

### G. SAFETY / ENVIROMENT

1. Do you live in a private house, apartment, mobile home other? (circle)
2. Do you know the hottest temp of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor where you live? Yes No
4. Does your child always use a seat belt / car seat in a car? Yes No
5. Do you forbid smoking in your house? Yes No
6. Is your home regularly inspected for health hazards such as peeling paint, insects, rats or mice? Yes No
7. Does your child wear a helmet when riding a bike? Yes No
8. Do you have any firearms in the home? Yes No
9. Do you have Syrup of IPECAC in your home? Yes No
10. Have any of the child's caregivers been trained in CPR? Yes No
11. Kids under 10 never cross streets alone? Yes No
12. Kids are always supervised in or near water? Yes No
13. Are children protected against falls from windows, stairs, Furniture and playground equipment? Yes No
14. Household cleaners, medicines and vitamins are stored out of young kids' reach? Yes No
15. Our home has emergency numbers near telephones and First aid supplies. Yes No

### H. DO YOU HAVE A RECORD OF IMMUNIZATIONS?

- Yes No  
If yes, please give immunization record to nurse with this form.

### LIST ANY OTHER QUESTIONS FOR THE DOCTOR

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

NAME OF PERSON COMPLETING FORM: \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ DATE \_\_\_\_\_ PHYSICIANS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**TB AND LEAD RISK FACTOR QUESTIONNAIRE**

**LEAD**

1. Does your child live in or regularly visit a house built before 1960 with peeling or chipping paint?  
This could include a day care, preschool, home or babysitter or relative etc.  
Yes No
2. Does your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling? Yes No
3. Does your child have a brother or sister, housemate or playmate with lead poisoning?  
Yes No
4. Does your child live with an adult whose job or hobby involves exposure to lead? (Examples Below)  
Yes No
5. Does your child live near a busy street or highway? Yes No

If you answered yes to any of these questions, your child is at risk for lead poisoning. The only way to know for sure is to have your child tested.

**OCCUPATIONAL AND HOBBY SOURCES OF LEAD POISONING**

1. Storage batteries (lead batteries)
2. Plumbing fixture fitting and trim (brass goods)
3. Bridge, tunnel, and elevated highway construction
4. Automotive repair shops
5. Using fitting ranges
6. Refinishing furniture
7. Making stained glass or pottery
8. Casting aluminum
9. Making fishing weights
10. Using lead solder
11. Using artists' paints that contain lead
12. Burning wood covered with lead-based paint

**TB**

1. Has your child had contact with an adult with TB? Yes No
2. Has your child been to, if from, or has had contact with persons from a region of the world with a high TB prevalence (Central and South America, Southeast Asia) or are the parents from one of these areas?
3. Is your child HIV positive? Yes No
4. Does your child have a nanny or caretaker who is from an area with high TB prevalence (include inner city dwellers)?  
Yes No
5. If your child in foster care? Yes No
6. Has your child had contact frequently with HIV infected individuals, homeless persons, IV / street drug users, poor and medically indigent city dwellers, nursing home residents, migrant farm workers, or a person who has been in prison within the past five year? Yes No