PERSON FAMILY MEDICAL AND DENTAL CENTER

PERSONAL and FAMILY HISTORY BELOW the Age of 10

Patient Name: _____ DOB: _____ Age: _____
Place of Birth: (City)_____ and (State)_____
Medicine Allergies: _____ Food Allergies: _____

Birth History: Type of Delivery - SVD ☐ C-Section ☐
Reason: _____
APGARS: _____ @1 minute _____ @5 minutes _____
Birth Weight: _____ lbs. _____ oz. _____ gms. Birth Length: _____ in. _____ cm.
Discharge Weight: _____ lbs. _____ oz. _____ gms. Circumcision: yes ☐ no ☐
Breast Feeding ☐ Bottle Feeding ☐
Formula: _____ _____ oz. _____ QH.

Mothers Name: _____ Age:_____ Phone Number: _____
Problems with Pregnancy? _____
Drug/Etoh? _____
Problems with L/D? _____
Do your parents smoke? yes ☐ no ☐ How much? _____

Patient Medical History	YES	DENIES
ADD/ADHD		
Alcoholism/Drugs		
Anemia		
Asthma		
Cancer (Please write type)		
Diabetes		
Epilepsy/Convulsions/Seizures		
Heart Problems (Please write type)		
High Blood Pressure		
High Cholesterol		
Kidney Problems		
Mental Illness (Please write type)		
Migraines		
Pneumonia		
Sickle Cell/Thal./Anemia		
Sleep Apnea		
Stroke		
Thyroid Disease (Hyper or Hypo)		
Other		

Family Medical History	MOM	DAD	CHILDREN	BROTHER	SISTER	MOTHER'S MOM	MOTHER'S DAD	FATHER'S MOM	FATHER'S DAD
Alcoholism/Drugs									
Asthma									
Cancer (Please write type)									
Diabetes									
Epilepsy/Convulsions/Seizures									
Heart Problems (Please write type)									
Hepatitis									
High Blood Pressure									
High Cholesterol									
Kidney Problems									

Consent to Treat Minor Patient-Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor or a dentist without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____ **DOB:**_____

For those occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

_____

☐Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent may only apply to **minors age 16 and older.**

This consent shall be in effect for: ☐Date_____**(only)**

☐Indefinitely, until revoked by written communication

AUTHORIZATION:

I (parent/legal guardian name)_____ request and authorize Person Family Medical and Dental Center and its personnel to deliver routine medical, dental, and/or behavioral healthcare to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Person Family Medical and Dental Center and its personnel to deliver routine medical, dental, and/or behavioral health treatment and services to my child. Routine medical and dental care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations), dental exams, hygiene cleanings, fillings, tooth extractions, and other treatments as deemed necessary.
I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____

Parent or Legal Guardian (please print) **Relationship**

_____

Parent or Legal Guardian Signature **Date**

PERSON FAMILY MEDICAL AND DENTAL CENTER

Family Medical History	MOM	DAD	CHILDREN	BROTHER	SISTER	MOTHER'S MOM	MOTHER'S DAD	FATHER'S MOM	FATHER'S DAD
Mental Illness (Please write type)									
Migraines									
Sickle Cell/Thal./Anemia									
Stroke									
Thyroid Disease (Hyper or Hypo)									
Other									

PATIENT MEDICAL HISTORY

List any **OTHER medical conditions** not listed above (diagnosis, if known) you have or have had, and how long you have had these problems (approximately). Write "none" if there are NO OTHERS.

_____

_____

_____

_____

List the **SURGERIES** (diagnosis, if known) you have had, when the surgeries were performed (approximately), and at what hospital. Write "none" if there are none.

_____

_____

_____

_____

List **HOSPITAL ADMISSIONS.** Include when (approximately), what hospital, and the reason you were admitted. Include important emergency room visits and severe accidents. Write "none" if there are none.

_____

_____

_____

_____

Scanned ALL shot Records **YES ☐ NO ☐** **Date/Time Scanned:** _____ **Initials:** _____

H/P Done By: _____ **Date Done:** _____