

|                 |               |
|-----------------|---------------|
| Appointment w/: | Today's Date: |
|-----------------|---------------|

**Patient Information:**

|                      |              |            |                      |          |
|----------------------|--------------|------------|----------------------|----------|
| Last Name            |              | First Name |                      | M        |
| Date of Birth        | Age          | Sex        | Marital Status       |          |
| Street Address       |              | City/State |                      | Zip Code |
| Home Phone # ( )     | Mobile # ( ) | Work# ( )  | Email                |          |
| Mother's First Name: |              |            | Father's First Name: |          |

**Employer Information:** This is for medical record purposes only.

|            |                         |
|------------|-------------------------|
| Occupation | Employer's Name/Address |
|------------|-------------------------|

**Emergency Contact Information:**

|      |              |             |
|------|--------------|-------------|
| Name | Relationship | Phone # ( ) |
|------|--------------|-------------|

**Referral Source (From whom/how did you hear about this Provider?):**

Name/Type:  Physician  Family or Friend  Website/ Search  Advertisement  Other \_\_\_\_\_

|                         |         |             |
|-------------------------|---------|-------------|
| Primary Care Physician  | Address | Phone# ( )  |
| Cardiologist            | Address | Phone# ( )  |
| Physician (Other) _____ | Address | Phone # ( ) |

**Insurance Information:**

|   |             |               |                        |                |
|---|-------------|---------------|------------------------|----------------|
| <b>Patient Relationship to Guarantor (circle one)</b> | <b>SELF</b> | <b>SPOUSE</b> | <b>DEPENDENT CHILD</b> | <b>STUDENT</b> |
| Primary Insurance                                     |             |               | Policy #               |                |
| Guarantor Name  |             |               | DOB                    |                |
| Secondary Insurance                                   |             |               | Policy #               |                |
| Guarantor Name  |             |               | DOB                    |                |

**Pharmacy Information:**

|                    |                        |                            |             |
|--------------------|------------------------|----------------------------|-------------|
| <b>Circle One:</b> | <b>Retail Pharmacy</b> | <b>Mail-Order Pharmacy</b> | Name        |
| Address            |                        |                            | Phone # ( ) |

**Authorization for Treatment and Release of Information**

I hereby authorize and direct the above named clinical practice having treated me, to release to governmental agencies, insurance carriers, or others financially liable for my medical care, all information needed to substantiate payment for such medical care; and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I furthermore authorize the treating physician/practice to take and use my photos for insurance predetermination and educational purposes.

**Financial Responsibility (For Provider Indicated in the "Appointment w/" section of this form)**

**Medicare Patients:** I request that payment of authorized health insurance benefits be made to me or on my behalf to the provider(s) for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

**Commercial/Other Insurance:** I hereby authorize direct payment of surgical/medical benefits to my provider, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsible for all services. Additionally, I understand that all bills are my responsibility if not paid by the carrier.

**Out of Network:** I understand that the doctor is a **non-participating provider** of my insurance and therefore I will be responsible for any balances on this account.

**Self-Pay:** I agree to pay at the time the services are rendered.

|  |                                   |      |
|--|-----------------------------------|------|
| I verify the accuracy of the above information and authorize treatment and release of information as indicated on this form. | Patient (Guardian) Signature<br>X | Date |
| I understand and agree to terms of my financial responsibility as indicated on this form.                                    | Patient (Guardian) Signature<br>X | Date |



COLUMBIA UNIVERSITY  
MEDICAL CENTER

New York Presbyterian  
Division of Plastic Surgery  
161 Fort Washington Avenue  
New York, NY 10032  
Office 212-305-9612 Fax 212-305-9626



New York-Presbyterian  
Plastic Surgery

# Pediatric Intake Form

## Our Philosophy of Patient Care

We thank you for taking the time to complete the following Medical History. We realize this may seem like a lot of information, especially if your condition does not seem related. However, we believe that it is important to have complete knowledge and understanding of your medical background in order to care for you and treat you properly. Many seemingly unrelated symptoms, points of family history, environmental exposures and many other factors can all contribute to your well-being. A thorough Medical History is also required by Medicare and Insurance companies, in accordance with government standards. This information will be compiled and entered into our electronic health record and will be available to other providers you may see in this facility. All patient information is kept confidential based on HIPAA Guidelines. It takes time to treat everyone properly and thoroughly. We ask for your patience while you are waiting to be seen.

Thank you.

## Pediatric Intake Form Section 1

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Last

Referring Physician \_\_\_\_\_ Today's Date \_\_\_\_\_

For specialist visits, list your child's pediatrician name and phone #: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Pharmacy Address \_\_\_\_\_  
 \_\_\_\_\_

What is the reason for your child's visit today? \_\_\_\_\_

If your child's problem causes pain, where is it painful? \_\_\_\_\_ How long has it been present? \_\_\_\_\_

Description of pain \_\_\_\_\_ When does it occur? \_\_\_\_\_ Severity \_\_\_\_\_

Any other symptoms? \_\_\_\_\_ What makes it better or worse? \_\_\_\_\_

Please list ALL of your child's current medications below (use back of page if you need more room)

| Medication Name | Dose | When is it given? | Approximate start date of medication |
|-----------------|------|-------------------|--------------------------------------|
|                 |      |                   |                                      |
|                 |      |                   |                                      |
|                 |      |                   |                                      |

Does your child take any non-prescription medications? Yes \_\_\_ No \_\_\_ If yes, list: \_\_\_\_\_

## Pediatric Intake Form Section 2

**Patient Name:** \_\_\_\_\_

**BIRTH HISTORY**

Which pregnancy is this child? \_\_\_\_\_ Did the mother have health problems during the pregnancy? Yes\_\_\_No\_\_\_

Describe: \_\_\_\_\_

Born by vaginal delivery or c/section? \_\_\_\_\_ If c/section, reason \_\_\_\_\_

How many months' gestation at birth? \_\_\_\_\_ Birth weight \_\_\_\_\_

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc) \_\_\_\_\_

Is your child adopted? Yes\_\_\_No\_\_\_ If Yes, *please describe the above to the best of your knowledge.*

**MEDICAL HISTORY:** HAS YOUR CHILD EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING

Anemia: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Asthma/Breathing Problems: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Allergies: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Arthritis: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Behavioral Problems: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Bleeding Tendency: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Bowel Problems: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Cancer/Leukemia: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Chicken Pox/Shingles: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Developmental Disorder: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Diabetes: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Ear/Nose/Throat (ENT) Disorder: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Eczema/Skin Disorder: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Eye Disorder : Yes\_\_\_No\_\_\_ \_\_\_\_\_

Growth Disorder: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Heart Disorder/Defect: Yes\_\_\_No\_\_\_ \_\_\_\_\_

High Blood Pressure: Yes\_\_\_No\_\_\_ \_\_\_\_\_

High Cholesterol: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Immune Deficiency Disorder: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Kidney/Urinary Disorder: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Liver Disease: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Seizure: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Thyroid Disorder: Yes\_\_\_No\_\_\_ \_\_\_\_\_

Any Other? Yes\_\_\_No\_\_\_ \_\_\_\_\_

### Pediatric Intake Form Section 3

**Patient Name:** \_\_\_\_\_

**FAMILY HISTORY:** Does your child have any family members with a history of major illness or conditions? List below:

| <b>RELATIVE</b> | <b>CONDITION &amp; DESCRIPTION</b> | <b>LIVING (Y/N)</b> | <b>IF DECEASED, AT WHAT AGE?</b> |
|-----------------|------------------------------------|---------------------|----------------------------------|
|-----------------|------------------------------------|---------------------|----------------------------------|

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparent: \_\_\_\_\_

Grandparent: \_\_\_\_\_

Other: \_\_\_\_\_

**SURGICAL HISTORY:** List any surgeries your child has had and the approximate date:

Has your child had a blood transfusion? Yes \_\_\_ No \_\_\_? If yes, when? \_\_\_\_\_

**SOCIAL HISTORY:**

Legal Guardian if other than parents: \_\_\_\_\_

Other people living in the home: \_\_\_\_\_

Does anyone living in your home smoke? Yes \_\_\_ No \_\_\_

Have you ever had problems with lead paint or contamination in your home? Yes \_\_\_ No \_\_\_

Do you have other children? Yes \_\_\_ No \_\_\_ If Yes, how many? \_\_\_ What are their ages? \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR OFFICE USE ONLY:**

CROWN-04-29-09 intake

*The following sections were entered into CROWN by (sign initials next to the section(s) you entered):*  
ALL \_\_\_\_\_ Problems \_\_\_\_\_ Allergies \_\_\_\_\_ Birth Hx \_\_\_\_\_ Medical Hx \_\_\_\_\_  
Family Hx \_\_\_\_\_ Surgical Hx \_\_\_\_\_ Social History \_\_\_\_\_  
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_



**COLUMBIA UNIVERSITY  
MEDICAL CENTER**

Health Insurance Portability and Accountability Act (HIPAA)  
HIPAA Compliance/Columbia University Medical Center  
601 West 168th Street, Apt. #22, 2nd Floor  
New York, NY 10032 / T (212) 342-0059 F (212) 342-5173  
<http://www.cumc.columbia.edu/hipaa/>

**NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT OF RECEIPT**

DATE: \_\_\_\_\_

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Signature

**If completed by a patient's personal representative, please print and sign your name in the space below**

\_\_\_\_\_  
Personal Representative (Print)

\_\_\_\_\_  
Personal Representative's Signature

\_\_\_\_\_  
Relationship

**For Columbia University Medical Center use only.**

Complete this section if this form is not signed and dated by the patient or patient's representative.

**I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:**

- Patient refused to sign
- Patient unable to sign
- Other \_\_\_\_\_

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date

**This form should be placed in the patient's medical record**