

Whether you are new to Mali & Mali Pediatrics or you have been with us for years, please help us update your child's history.

MEDICAL HISTORY

Child's Name: _____ **Date of Birth:** _____

<u>Has your child ever had:</u>	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Details</u>
Abdominal pain (frequent)	Y	N	DK	_____
ADD or ADHD	Y	N	DK	_____
Allergies	Y	N	DK	_____
Anemia	Y	N	DK	_____
Asthma/Bronchitis/Bronchiolitis/Pneumonia	Y	N	DK	_____
Bedwetting	Y	N	DK	_____
Bladder/Kidney Problems	Y	N	DK	_____
Blood diseases/Blood Transfusion	Y	N	DK	_____
Cancer	Y	N	DK	_____
Chicken Pox	Y	N	DK	_____
Congenital Anomalies	Y	N	DK	_____
Constipation	Y	N	DK	_____
Developmental/Behavioral Disorders	Y	N	DK	_____
Diabetes	Y	N	DK	_____
Ear or Hearing Problems	Y	N	DK	_____
Headache (frequent)	Y	N	DK	_____
Heart Problems	Y	N	DK	_____
Hospital Admission other than birth	Y	N	DK	_____
Menstrual Problems (females only)	Y	N	DK	_____
Muscle, Joint, or Bone Problems	Y	N	DK	_____
Other	Y	N	DK	_____
Seizures/Epilepsy	Y	N	DK	_____
Serious Illness or Injuries	Y	N	DK	_____
Skin Problems	Y	N	DK	_____
Substance Abuse	Y	N	DK	_____
Thyroid Problems	Y	N	DK	_____
Vision or Eye Problems	Y	N	DK	_____

FAMILY HISTORY – Has anyone in your family ever suffered from:

Children's Names: _____

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Relative</u> (for example: mother or paternal grandfather)
Alcohol/Substance Abuse	Y	N	DK	_____
Allergies	Y	N	DK	_____
Anemia	Y	N	DK	_____
Asthma	Y	N	DK	_____
Bed-wetting (after 10 years old)	Y	N	DK	_____
Bleeding Disorders	Y	N	DK	_____
Cancer	Y	N	DK	_____
Deafness/Hearing Problems	Y	N	DK	_____
Developmental Disorders	Y	N	DK	_____
Diabetes	Y	N	DK	_____
Epilepsy/Seizures	Y	N	DK	_____
Headaches/Migraines	Y	N	DK	_____
Heart Problem	Y	N	DK	_____
High Cholesterol	Y	N	DK	_____
Hypertension	Y	N	DK	_____
Immune Problems	Y	N	DK	_____
Kidney Disease	Y	N	DK	_____
Mental Illness (depression/anxiety/etc.)	Y	N	DK	_____
Other	Y	N	DK	_____
Thyroid Problems	Y	N	DK	_____
Tuberculosis	Y	N	DK	_____

SOCIAL HISTORY:

Details

Names of Siblings	_____				
Childcare	none	relative	nanny/sitter	daycare	_____
Child lives with:	both parents	mother	father	other	_____
Parents are:	married	unmarried	separated	divorced	widowed _____
Passive smoke exposure	No	Yes	_____		
Animal exposure	No	Yes	_____		
Diet	Regular	Vegetarian	Vegan	Gluten-free	other _____
Fluoridated water	Yes	No	_____		
Caffeine intake	None	Occasional	Moderate	Heavy	type _____
Exercise level	None	Occasional	Moderate	Heavy	activity _____
Smoke/CO detectors in home	Yes	No	_____		
Car seat/seat belt used routinely	Yes	No	_____		
Sunscreen used routinely	Yes	No	_____		
Insect repellent used routinely	Yes	No	_____		
Guns in the home	No	Yes	_____		

Mali and Mali Pediatrics Family Information Form

Complete for all children on the same policy. Use separate form for children on different policies.

First Name	Last Name	Gender (circle)	Birth Date (MM/DD/YR)
1 st Child _____	_____	M or F	_____
2 nd Child _____	_____	M or F	_____
3 rd Child _____	_____	M or F	_____
4 th Child _____	_____	M or F	_____

Primary Insurance _____ Policy Number _____ Group Number _____

Subscriber Name _____ Birth Date _____

If applicable complete secondary insurance information below:

Secondary Insurance _____ Policy Number _____ Group Number _____

Subscriber Name _____ Birth Date _____

PARENT INFORMATION

Mother

Father

Name _____

Name _____

Birth Date _____ Social Security _____

Birth Date _____ Social Security _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Phone (Home) _____ (Cell) _____

Phone (Home) _____ (Cell) _____

Employer _____ (Work) _____

Employer _____ (Work) _____

Email _____

Email _____

Assignment of Benefits(Authorization for your insurance to pay us)

I authorize the release of any medical information necessary to process claims. I authorize payment of medical benefits directly to the physician. I understand that I am financially responsible for all co-payments, deductibles, and services not covered by my insurance company for any reason.

Authorized Signature _____ Date _____ Relationship _____

Mali & Mali Pediatrics

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Mali & Mali Pediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more completed description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Mali & Mali Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Vik Mali, M.D., the Privacy Officer at Mali & Mali Pediatrics, at the above address.

With my consent , the staff at Mali & Mali & Mali Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the staff at Mali & Mali Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent and if and when available, the staff at Mali & Mali Pediatrics may e-mail appointment reminders and patient statements. I have the right to request that Mali & Mali Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Mali & Mali Pediatrics' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Mali & Mali Pediatrics may decline to provide treatment to me.

Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian

Print Name of Patient

Date

Receipt of Vaccine Policy and Financial/Billing Policy

My signature below indicates that I have received and reviewed the vaccine and financial/billing policies set forth by Mali and Mali Pediatrics.

Signature of Parent or Legal Guardian

Date