Lane PEDIATRICS

Lane Pediatrics, PA
9260 Estero Park Commons Blvd.
Suite 100
Estero, FL 33928
P (239) 908-3593 F (239) 908-3597

**PATIENT INFORMATION**

Full Name ____________________________________________ DOB ____________
First Middle Last

Home Address ____________________________________________
Street Address Apartment/Unit #

____________________________________________
City State Zip Code

Phone (______)______________ ☐ Cell ☐ Home Email ______________________

Primary Language(s) ______________________

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Sibling(s) and birthdate(s) ____________________________________________

____________________________________________

**PREFERRED PHARMACY** ____________________________________________
Name Phone Number

**PRIMARY INSURANCE (IF CARRIED)**

Insurance Company ______________________

Name of Policy Holder ______________________________ DOB ____________

Policy # ______________________ Group # ______________________

## PARENTS/LEGAL GUARDIANS

Parent's Name ______________________________________________ DOB ____________
First Last

Home Address ______________________________________________________________
Street Address Apartment/Unit #

______________________________________________________________________________
City State Zip Code

Phone (_____)____________ ☐ Cell ☐ Home Email _______________________________

Parent's Name ______________________________________________ DOB____________
First Last

Home Address ______________________________________________________________
Street Address Apartment/Unit #

______________________________________________________________________________
City State Zip Code

Phone (_____)____________ ☐ Cell ☐ Home Email _______________________________

## EMERGENCY CONTACT (OTHER THAN ABOVE)

Full Name __________________________________________________
First Last

Phone (_____)____________ ☐ Cell ☐ Home Relationship ____________________

## I AUTHORIZE THE FOLLOWING ADULTS TO ACCOMPANY MY CHILD TO APPOINTMENTS AND MAKE NECESSARY MEDICAL DECISIONS:

______________________________________________________________________________

______________________________________________________________________________

I certify that the above information is accurate and true, to the best of my knowledge.

__________________________________________ ______________
Signature of Patient/Parent/Legal Guardian Date

# AUTHORIZATION FOR RELEASE OF INFORMATION

**PATIENT NAME:**_______________________________________________ **DOB:** ___________

Last First Middle

**AUTHORIZES:**__________________________________________________________________

Name of Previous Pediatrician City, State

Phone: ______________________ Fax: _____________________

**TO DISCLOSE TO:** Lane Pediatrics, PA
9260 Estero Park Commons Blvd.
Suite 100
Estero, FL 33928
P (239) 908-3593 F (239) 908-3597

**DATE(S) OF INFORMATION TO BE DISCLOSED:** From ____________ to ____________

Month/Year Month/Year

If left blank, only information from the past two (2) years will be disclosed.

**INFORMATION TO BE DISCLOSED:**

☐ All medical records related to (specify condition, treatment, etc): ______________________________
☐ Radiology images/reports (specify test): ______________________________________________
☐ Specific records/information as follows: ___Last WCC, most recent visit, immunization records, growth charts _____________________________________________________________________

**I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:**

☐Alcohol/drug abuse ☐ HIV test results ☐ Mental health

**EXPIRATION:** This authorization is good until the following date/event: ___________
If this item is left blank, the authorization will expire in one (1) year from the date signed.

**PURPOSE:** ☐Further medical care ☐ Personal records ☐ Other______________________________

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I agree to release the above named facility, it's affiliates, employees, and physicians from all legal responsibility and liability that may arise from the disclosure and/or unauthorized redisclosure of such information. I understand that I have a right to revoke this authorization at any time, and I must do so in writing. I understand that the revocation will not apply to the information which has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I understand that I do not need to sign this authorization in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed.

**SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:** **DATE:**

_______________________________________________ __________

Relationship: ___________________

# Pediatric Health History Form

**CHILD'S NAME:** ________________________________ **DATE OF BIRTH:** ____________ **AGE:** ______

**CHILD'S PREVIOUS DOCTOR/PCP:** ______________________________________________________

**BIRTH AND PREGNANCY**

What city was your child born in? _____________________ Name of hospital: _______________________

Is this your child by: ______ Birth ______ Adoption ______ Step-child Other: ________________

Birth weight: _____________________ Was your baby premature? **Y / N**

Were there any significant medical problems during your pregnancy? **Y / N**

Were there any significant complications during labor or the baby's newborn period? **Y / N**

If yes to any of the above questions, please explain: ____________________________________________

______________________________________________________________________________________

**GROWTH AND DEVELOPMENT:**

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/ language, social skills, motor skills, etc)? **Y / N**

If yes, please explain: ____________________________________________________________________

Girls only: Age at first period: ______

**PAST MEDICAL HISTORY:**

HAS YOUR CHILD:

Had any serious medical illness? **Y / N**

Had a history of asthma or wheezing? **Y / N**

Ever used an inhaler or nebulizer? **Y / N**

Had surgery? **Y / N**

Had any broken bones/frequent or severe sprains? **Y / N**

Had any mental or behavioral problems? **Y / N**

Had a positive tuberculosis skin test? **Y / N**

Been hospitalized overnight? **Y / N**

If yes to any of the above questions, please explain: ____________________________________________

______________________________________________________________________________________

**IMMUNIZATIONS:** ***Please bring your child's immunization records to your appointment.***

Have you ever refused vaccines for your child? **Y / N**

If yes, why? _______________________________________________________________________________

**MEDICATIONS AND ALLERGIES**

Please list current medications, vitamins, and supplements, even those used intermittently: _______________

______________________________________________________________________________________

Please list any allergies or reactions to medications, vaccines, or foods:

| Allergy | Reaction |
|---|---|
| ____________________ | ________________________________ |
| ____________________ | ________________________________ |
| ____________________ | ________________________________ |

**FAMILY HISTORY:**

| Medical Condition | Mom | Dad | Sister | Brother | Mom's Mom | Mom's Dad | Dad's Mom | Dad's Dad | Mom's Sister | Mom's Brother | Dad's Sister | Dad's Brother |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol/Substance Abuse | | | | | | | | | | | | |
| Anemia | | | | | | | | | | | | |
| Asthma | | | | | | | | | | | | |
| Autism | | | | | | | | | | | | |
| Autoimmune Disorder | | | | | | | | | | | | |
| Birth Defect | | | | | | | | | | | | |
| Bleeding Problem | | | | | | | | | | | | |
| Cancer, Breast | | | | | | | | | | | | |
| Cancer, ________ | | | | | | | | | | | | |
| Cancer, ________ | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | |
| Eczema | | | | | | | | | | | | |
| Food Allergy | | | | | | | | | | | | |
| Genetic Disorder | | | | | | | | | | | | |
| Hay Fever (Allergies) | | | | | | | | | | | | |
| Hearing Disorder | | | | | | | | | | | | |
| Heart Attack | | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | | |
| Immune Disorder | | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | | |
| Mental Illness | | | | | | | | | | | | |
| Mental Retardation | | | | | | | | | | | | |
| Migraines | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | |
| Thyroid Disorder | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |

**SOCIAL HISTORY:**

Are your child's parents: _______ Married _______ Unmarried _______ Separated _______ Divorced

Child-care situation: _______ Parents _______ Others (specify who and hours per day) ____________________

Is violence at home a concern? **Y / N**

Are there guns in the home? **Y / N**

Are there pets in the home? **Y / N**

Do any family members smoke? **Y / N**