Acknowledgement of Office Documents

Jill A. Johnston, MD, FAAP
Kevin M. Ponciroli, MD, FAAP

793 Sunset Blvd. O'Fallon, IL 62269
P: 618-668-BIRD (2473) F: 833-989-2239

www.redbirdpediatrics.com

Please list all children that receive care at Redbird Pediatrics.

Patient Name:________________________________ Date of birth:__________________

Patient Name:________________________________ Date of birth:__________________

Patient Name:________________________________ Date of birth:__________________

Patient Name:________________________________ Date of birth:__________________

Patient Name:________________________________ Date of birth:__________________

Patient Name:________________________________ Date of birth:__________________

Patient Name:________________________________ Date of birth:__________________

Patient Communication Preferences:

I give this practice and its representatives consent to leave messages on my voicemail or answering machine, including the use of Protected Health Information (PHI).

I do NOT give this practice and its representatives consent to leave messages on my voicemail or answering machine.

We also need to know if there are specific people you will want us to communicate with (using PHI) that are not legal guardians of your child(ren), for example a step-parent, babysitter or grandparent, who may need to call our office with a question or bring your child in for an appointment. Please list those people below.

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

This form serves as confirmation of receipt of all office policy documents from Redbird Pediatrics, PLLC. I have read and understand the following documents:

- **Welcome to Redbird Pediatrics**
- **Notice of Privacy Practices**
- **Assignment of Benefits & Release of Information**
- **Vaccine Policy**
- **Recommended Well Check Schedule**

I hereby authorize Redbird Pediatrics, PLLC and its affiliates, its employees and agents, to use and disclose Protected Health Information (PHI) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any PHI or other information released may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services

Legal Guardian Name: ______________________________________ (please print)

Legal Guardian Signature: ____________________________________ Date: ____________

Relationship to patient: ______________________________________

Welcome to Redbird Pediatrics

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Our mission at Redbird Pediatrics is to provide personalized, high-quality healthcare to all children from newborns to college kids. We are dedicated to improving and maintaining your child's health through preventative care and treatment of both acute and chronic medical issues. Our Board-Certified Pediatricians combine for over 30 years of experience seeing patients in St. Clair County. We offer a broad array of services geared to address today's most common health issues and illnesses:

- **Preventative Care/Well-Child Visits**: Keeping your children healthy is our primary goal. We offer well-child checkups to monitor your child's growth and development and provide anticipatory guidance for every age. During these visits, we provide vaccines, recommended screening tests, and follow up on chronic medical issues. We provide everything needed for day-care, school, and sports physicals.
- **Newborn Care and Lactation Assistance**: We begin care of your new baby starting at their first office visit just 1-2 days after leaving the hospital. We thoroughly review everything needed to care for your newborn, including feeding issues, normal development, pooping/peeing, jaundice (yellowness of the baby), sleep habits, and safety guidance. New moms especially need support and information when learning to breastfeed. We offer in-office consultations with Dr. Johnston to help moms overcome any challenges they may face in breastfeeding their baby.
- **Immunizations**: One of the most important services we can provide to our patients is vaccinations against life-threatening diseases. As medical professionals, we feel that vaccinating children following the recommended schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.
- **Sick Visits**: As a parent, when your child is sick, you want one thing: to get him or her better as soon as possible. At Redbird Pediatrics, we are committed to getting your children into our office as quickly as possible. At every visit, we take the time to discuss your child's symptoms, diagnosis, and treatment options. This includes the rational use of antibiotics, labs and imaging when they are indicated.
- **In-office Laboratory Services**: We offer a variety of rapid-result, in-office tests to help diagnose many common pediatric illnesses, including strep throat, influenza, Respiratory Syncytial Virus (RSV), anemia (low hemoglobin), lead toxicity, kidney and urinary tract diseases, cholesterol/lipid abnormalities, and COVID-19.
- **Virtual Visits**: Virtual visits are a great way to obtain care for common issues without having to bring your child into the office. With our virtual visit option, you are able to get the same great care from your child's pediatrician via your smartphone, just like you would if you were being seen in person.
- **Behavioral Health Visits**: Frequent monitoring of development and school-performance is vital in maintaining healthy kids. We routinely screen younger children for Autism and offer evaluation and treatment for kids with Attention Deficit Hyperactivity Disorder (ADHD).
- **Mental Health Visits**: Many children have fears and worries, and may feel sad and hopeless from time to time. Anxiety and depression can affect more that 10% of kids before the age of 17. We evaluate, treat, and help facilitate a team-based approach to your child's mental health issues.

Office Information

Office Hours:
The office is open 8:30 AM to 5:00 PM Monday through Friday. At this time we are not offering Saturday hours, but hope to add them in the future. The office is closed daily for lunch from 12:00-1:00 PM.

Questions During Office Hours:
During office hours, the nursing staff and doctors will be happy to help answer any questions. Please allow us time to check the messages and return the calls. If there is a prescription to be called in, please allow us time to complete the request and call the pharmacy prior to picking up the prescription to ensure that the medication is ready.

Contacting the Doctor After Hours:
If you have an emergency with your child, please call 911. If you have an urgent issue and need to reach one of the doctors during lunch or after hours, call the office at **618-668-BIRD (2473)**. You will be informed of which physician is on call and instructed on how to reach them. After hours calls should be reserved for ***urgent questions only***.

Scheduling Appointments:
You may call the office or schedule your child's next exam in person. Please allow plenty of time to schedule well-child exams, especially during school physical season. If your child is sick, you may call the office to schedule a time to be seen.

Insurance, Billing, and Vaccine Coverage
We accept most insurance plans. It is your responsibility to verify network participation, covered benefits and eligibility on your plan, and vaccine coverage before each of your child's appointments. It is also your responsibility to update our office of all insurance and address changes at the time of service.

Payment:
All copays are due at time of visit. The person bringing the child in for services is responsible for payment. You may pay with cash, check, American Express, Visa, MasterCard, or Discover Card.

Cancellation Policy:
If you are unable to make it to your scheduled appointment time and need to cancel, please call at least 24 hours ahead of time. If it is after hours, you can call and leave a message. Any appointment cancelled less than 24 hours prior to the scheduled time will be charged a **$25.00 fee**. If you fail to bring your child to an appointment without notification, a **$50.00 fee** will be assessed to your account. After the third missed appointment, you may be dismissed from the practice.

Work-In or Add-On Appointments:
If you wish to have the doctor see another child in addition to the one scheduled for the appointment, a fee of **$15.00** plus the standard co-pay will apply.

Returned Check Fee:
There will be a **$25.00 fee** applied to all returned checks. After a total of three returned checks per family, you will no longer be allowed to pay with checks.

Copies of Medical Records:
Requests for copies of medical records must be in writing. Please allow plenty of time to compile your child's medical record and prepare it for transmission to the desired office. Various fees may apply.

Request for Prescription Refills, Shot Records, Physical Forms for School:
You may call, fax or request in person or through our patient portal prescription refills, shot records, or physical forms for school. Please allow 24 hours for the request to be completed. Any urgent prescription requested and filled outside of normal business hours will incur a **$15.00 fee** to your account.

Immunization Records:
Please bring in an up-to-date immunization record with you to your child's well exams. We cannot give any additional vaccinations, until we have a copy of all shots given. In addition, we are unable to release school physical forms without an up to date shot record.

Notice of Privacy Practices

Jill A. Johnston, MD, FAAP
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

In this Notice, "protected health information" or "PHI" refers to any individually identifiable information that we obtain from you or another person that relates to your or your child's past, present, or future physical or mental health conditions, the health care you or your child has received or the payment for your care. Protected health information includes, but is not limited to:

- Demographic information (such as age, gender, race, ethnicity, or marital status);
- Geographic information (such as where you live or work);
- Medical information about health conditions (such as test results);
- Information about the services you have or will receive (such as an X-ray or surgical procedure);
- Information about your health insurance plan (such as your insurer's coverage policies);
- Information that may identify you (such as your Social Security Number or a phone number);
- Full-face photographs

Uses and Disclosures

Treatment: Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your PHI may be used to seek payment from your health plan, from other sources such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the service provided and the medical conditions being treated. You have the right to request your insurance company not be billed for any/all services/products rendered.

Health Care Opportunities: Your PHI may be used as necessary to support the activities of Redbird Pediatrics, PLLC. For example, information on the service you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement: Your PHI may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Also, all immunizations are automatically recorded in a state database.

Appointment Reminders: Your PHI may be used by our staff to send you appointment reminders via email, phone call, or text.

Information About Treatment: Your PHI may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products or services that we believe may interest you.

Other uses and disclosures require your authorization: Disclosure of your PHI or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us in writing of your decision to revoke.

Individual Rights: You have certain individual rights under the federal privacy standards. These include the right to request restriction on the use and disclosure of your PHI. The right to receive confidential communications concerning your medical condition and treatment. The right to inspect and copy your PHI. The right to amend and submit corrections to your PHI. The right to receive an account of how and to whom your PHI is disclosed. The right to receive a printed copy of this notice. The right to be notified of any breach of secured /unsecured PHI. If you request PHI be emailed to you, you acknowledge encryption is not required.

Redbird Pediatrics PLLC Duties: We are required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Practices. We are also required to abide by the privacy policies and practices that are outlined in this Notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all PHI we maintain.

Requests to Inspect PHI: You may generally inspect or copy the PHI that we maintain. As permitted by federal regulation, we require that requests to inspect or copy PHI be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You may also be charged for copies of your records.

Complaints: If you would like further information about, or to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Privacy Officer
Redbird Pediatrics, PLLC
793 Sunset Blvd.
O'Fallon, IL 62269

If you feel your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint. We will never "sell" your PHI or use it for fundraising.

(Last updated December 1, 2020)

Assignment of Benefits & Release of Information

Jill A. Johnston, MD, FAAP
Kevin M. Ponciroli, MD, FAAP

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1. In consideration of services rendered, I hereby transfer and assign to Redbird Pediatrics, PLLC and to the licensed physicians, groups, or individuals who perform services for my child, all of my right, title, and interest in any payment for services described herein as provided in any health insurance or similar policy or employee benefit plan.
2. I understand that Redbird Pediatrics, PLLC participates with many, but not all, insurance plans. It is my responsibility to contact my insurance company to verify that Redbird Pediatrics participates with my plan.
3. I understand that I am responsible for providing all insurance information at the time of admission to allow for verification. I hereby certify that the insurance information that I provide is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am aware there is a time limit on how long Redbird Pediatrics, PLLC may have to file insurance claims. If an insurance company denies payment for incomplete or wrong information or if a deadline is missed because I did not provide the correct information, I understand it is my responsibility to make payment in full.
4. I acknowledge and agree that I am responsible for all charges for services provided to my child(ren) which are not covered by my plan or for which I am responsible for payment under my plan. To the extent no coverage exists under my plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my plan.
5. I understand that all co-pays and deductibles are due at the time of service. If I have no insurance coverage, I understand payment is due at the time of service unless prior arrangements have been made. I understand that should my check be returned as unpaid by my bank for any reason I will be charged $25.00 in addition to the amount of the check that was written. I understand that these charges need to be paid before the next appointment or within two weeks of notice, whichever comes first.
6. I understand that should my account become delinquent for amounts the insurance company has determined are my responsibility, I may not be permitted to bring my child for routine well visits or school physicals until the obligation has been satisfied in full. This includes all prior co-pays.
7. I understand that I must give 24 hours notice if I need to cancel or reschedule an appointment. If I fail to cancel my child's appointment within 24 hours, I understand a $25.00 fee will be assessed to my account. If I miss an appointment ("no show"), a $50.00 fee will be assessed to my account. I understand all fees are expected to be paid prior to being seen at the next appointment. After the third "no show" appointment per family, I understand that the physician/patient relationship between my family and Redbird Pediatrics, PLLC may be terminated.
8. **Release of Information**: I authorize Redbird Pediatrics, PLLC to furnish requested information from my child's medical record to: (1) any insurance company, third-party payor, governmental agency, or workers' compensation carrier for the purpose of obtaining payment, and (2) any representatives of local, state, or federal agencies in accordance with law. Such information may include information concerning communicable diseases. I authorize the release of information from or the review of my child's medical record for the purpose of conducting any medical audits, utilization reviews, or quality assurance reviews. I further authorize Redbird Pediatrics, PLLC to release information from or copies of my child's medical record to my referring physician or to any other health care facility or provider to which my child may be transferred or referred.
9. **Medication History Authority**: I grant Redbird Pediatrics, PLLC Medication History Authority for my child, which gives permission to download my child's medication history from Pharmacy Benefit Managers (PBMs). This ensures the most complete view of my child's medication history, which can then be reconciled with his/her medical record for improved medication management and to assist in clinical decision making.
10. **I-CARE**, or Illinois Comprehensive Automated Immunization Registry Exchange, is a web-based immunization record-sharing application developed by the Illinois Department of Public Health (IDPH). I authorize Redbird Pediatrics, PLLC to release immunization information to I-CARE for the purposes of record completion and community/county tracking.

(Last Updated January 31, 2020)

REDBIRD pediatrics PLLC
Exceptional care to help your kids take flight

Vaccine Policy

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One of the most important services we can provide to our patients is vaccinations against life threatening diseases. As medical professionals, we support vaccinating children according to the recommended schedule set forth by the American Academy of Pediatrics. The recommended vaccines and vaccine schedule are the result of years of scientific study on millions of children by thousands of our brightest scientists and physicians. When you don't vaccinate, you take a significant risk with your child's health and the health of others around them. Therefore, for the safety of our patients and families, we fully support vaccinations.

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics (AAP).
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers.

We recognize that the choice may be a very emotional one for some parents. We will educate you regarding vaccine safety and the dangers in delaying or refusing vaccinations. We firmly believe that vaccinating according to the schedule is the right thing to do. However, should you have doubts, please discuss these with your healthcare provider in advance of your visit. In some cases, we may alter the schedule to accommodate parental concerns or reservations. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness or even death. Therefore, it goes against our medical advice as providers at Redbird Pediatrics. Such additional visits will require additional co-pays on your part. Please realize that you will also be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays. **If you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views**.

As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Thank you for taking the time to read this policy. Please feel free to discuss any questions or concerns you may have about vaccines with us.

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Recommended Well Check Schedule

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Age	Immunizations and Screening Tests
Newborn	Hepatitis B (if not given in the hospital)
2 weeks	No vaccines if up to date
1 month	No vaccines if up to date
2 months	Pediarix (DTaP-IPV-Hep B), Hib, Prevnar (Pneumococcal), Rotavirus
4 months	Pediarix, Hib, Prevnar, Rotavirus
6 months	Pediarix, Prevnar
9 months	No vaccines if up to date, Lead test if risk factors noted
12 months	MMR (Measles-Mump-Rubella), Varicella (Chickenpox), Hepatitis A, Hemoglobin/Lead test
15 months	DTaP, Hib, Prevnar
18 months	Hepatitis A, Lead screening (test if risk factors noted)
24 months	No vaccines if up to date, Lead screening (test if risk factors noted)
3 years	No vaccines if up to date, Lead screening (test if risk factors noted)
4 years	MMR, Varicella (may be given as combination vaccine Proquad) and DTaP, IPV (may be given as combination vaccine Kinrix), Lead screening (test if risk factors noted)
5 years	No vaccines if up to date, Lead screening (test if risk factors noted)
6-8 years	Recommend yearly check-up, No vaccines if up to date
9-10 years	Recommend yearly check-up, No vaccines if up to date, screening non-fasting lipid panel
11 years	Meningococcal (MCV, Menveo), Tdap, Gardasil (HPV, series of 2 if completed prior to age 15 years)
12 years	Gardasil (HPV) if not completed
13-15 years	Recommend yearly check-up, No vaccines if up to date
16 years	Meningococcal, screening non-fasting lipid panel
17-18 years	Bexsero
18+ years	Recommend yearly check-up

We also recommend a yearly Influenza vaccine for all children age 6 months and older.

Authorization for Release of Health Information

Jill A. Johnston, MD, FAAP
Kevin M. Ponciroli, MD, FAAP

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Patient Name: ____
Last First MI

Date of Birth: ______________________ Social Security Number: _________ -- ______ -- _________
MM/DD/YYYY

I authorize and request: ____
Name of Physician or Medical Facility

____
Street Address

____
City State Zip

To release to: ☐ Redbird Pediatrics, PLLC
793 Sunset Blvd.
O'Fallon, IL 62269

or

____
Name of Physician or Medical Facility

____
Street Address

____
City State Zip

What should be released:
- ☐ Complete medical records
- ☐ Medical records for the period from ___________________ to ___________________
- ☐ Immunization records only

Disclosure of confidential information: (Please check all that apply)
- ☐ I consent to the disclosure of medical information that may include chemical or alcohol dependence or psychiatric care including Attention Deficit Hyperactivity Disorder (ADHD).
- ☐ I consent to the disclosure of medical information that may include blood tests that have been done to detect antibodies to or levels of HIV which is the probable cause of Acquired Immune Deficiency Syndrome (AIDS).

Requested medical information is needed for:
- ☐ Transfer of care to Redbird Pediatrics, PLLC
- ☐ Other: ____

I understand that my medical records or the medical record of the patient for whom I am signing may include alcohol/drug abuse, psychiatric treatment or HIV/AIDS testing or treatment and are covered by Federal Regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event, this consent will expire on ___________________ or ninety (90) days from the date the authorization is signed. I understand that any fees assessed for copying records of the PHI (as determined by Illinois Public Act 92-228) are my responsibility. **Redbird Pediatrics, PLLC,** its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

______________________________ ______________________ ______________
Patient Signature or Legal Representative Relationship to Patient Date

______________________________ ______________
Witnessed By Date

Patient Information Form

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Patient Name: ______________________ Date of Birth: ______________________

Street Address: ______________________ Gender: ☐ Male ☐ Female

City / State / Zip: ______________________ Primary Physician: ☐ Jill Johnston, MD ☐ Kevin Ponciroli, MD

How did you hear about our office? ☐ Previous Patient ☐ Friend/Neighbor ☐ Insurance Co. ☐ Internet ☐ Other

Name of First Parent: ______________________ Date of Birth: ______________________

Street Address: ______________________ Home Phone: ______________________

City / State / Zip: ______________________ Cell Phone: ______________________

Drivers License No: ______________________ SSN: ______________________

Name of Second Parent: ______________________ Date of Birth: ______________________

Street Address: ______________________ Home Phone: ______________________

City / State / Zip: ______________________ Cell Phone: ______________________

Drivers License No: ______________________ SSN: ______________________

Primary Insurance Information

Insured Name: ______________________ Date of Birth: ______________________

Name of Employer: ______________________ Copay: ________ Preventive Coverage? ☐ Y ☐ N

Policy ID: ______________________ Group Number: ______________________

Secondary Insurance Information

Insured Name: ______________________ Date of Birth: ______________________

Name of Employer: ______________________ Copay: ________ Preventive Coverage? ☐ Y ☐ N

Policy ID: ______________________ Group Number: ______________________

Emergency Contact Person: ______________________ Daytime Phone: ______________________

List name, gender, and birth date of all siblings: ______________________ ______________________

______________________ ______________________ ______________________

Please bring patient's insurance card to every visit. Parents/Guardians are responsible for notifying our office of changes of address and/or insurance coverage. Please note that whoever brings the patient(s) to their appointment is responsible for paying the Insurance Co-pay if applicable. When writing a personal check, please have Drivers License or State ID available.

Authorization To Release Medical Information: I hereby authorize Redbird Pediatrics to release any information acquired in the course of my examination or treatment to any insurance company against which claims are filed on my behalf. I hereby authorize payments directly to Redbird Pediatrics of the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for payment of all charges for services rendered and that if my insurer fails to pay any portion of these charges for any reason, I will be responsible for all sums due Redbird Pediatrics. If my account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

______________________________________ ______________________

Signature of Patient or Legal Guardian Date

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Patient Name: ______________________________ **Date of Birth**: ____________
Last First MI (MM/DD/YYYY)

Is the patient adopted? ☐ Yes ☐ No If yes, in what country was the patient born? ____________
Is the patient currently in foster care? ☐ Yes How long has he/she been in your care? ____________

Allergies to medication, food, or environment: ____________

Pre-existing medical conditions: ☐ Asthma ☐ Heart Disease ☐ Allergies ☐ Eczema ☐ Diabetes ☐ Autism ☐ ADHD
Other: ____________

Current medications (and dosages): ____________

List any hospitalizations or surgeries: ____________

FOR CHILDREN UNDER 1 YEAR OLD **Check any that occurred during the pregnancy with this child:**
☐ Group B Strep. ☐ Hospitalizations ☐ Tobacco / Alcohol / Marijuana / other Drug Use ☐ High Blood Pressure
☐ Gestational Diabetes ☐ Infections Other: ____________

Birth History ☐ Term (>37 weeks) ☐ Born Premature @ ____ weeks ☐ Single ☐ Multiple Birth
Mother's age at child's birth: ______ Father's age: ______ Birth Weight: ______ Birth Length: ______
Hospital: ______ Labor: ☐ Induced ☐ Spontaneous Delivery: ☐ Vaginal ☐ Cesarean ☐ Breech (feet first)
Feeding: Breast Bottle Complications: ____________

Growth and Development Did growth occur at a normal rate? ☐ Yes ☐ No. Indicate in what month the milestone was reached:
Walked unsupported: ______ Spoke words: ______ Spoke sentences: ______ Toilet trained: ______
Describe any current developmental issues: ____________

Social Factors Who does this child live with? ______ Parents Married? ☐ Yes ☐ No ☐ Multiple Households
☐ Siblings. How many? ______ Others in home: ______
Parent's Occupation: ______ Parent's Occupation: ______
Does anyone living with this child smoke? ☐ Yes ☐ No Who? ______
Are there firearms located in the house? ☐ Yes ☐ No Pets in home? ☐ Yes ☐ No What kind? ______
Where does this child live? ☐ Home ☐ Apartment ☐ Other How old is this residence? ______

Family Medical History Check if child's natural parents, siblings, aunts, uncles or grandparents have had any of the following. Also, please indicatewhich family member has/had that condition (MGM –maternal grandmother, etc)

☐ High Blood Pressure ______
☐ High Cholesterol ______
☐ Heart Attack / Stroke before age 55 ______
☐ Sudden Death (cardiac, etc.) ______
☐ Diabetes ______
☐ Allergies ______
☐ Eczema ______
☐ Asthma ______
☐ Cancer ______
☐ Blood Disorders ______
☐ Sight / Hearing Problems ______
☐ Gastrointestinal disease ______
☐ Kidney disease ______
☐ Liver Disease ______
☐ Epilepsy / Seizures ______
☐ Headaches ______
☐ Developmental Delay ______
☐ Autism Spectrum Disorder ______
☐ Hyperactivity / ADHD ______
☐ Alcohol / Drug Addiction ______
☐ Emotional Problems ______
☐ None of the above. ☐ **Family History not known**