Patient Registration Paperwork

We look forward to assisting you!!

Main Location:
#1 Southtowne Dr
Potosi, MO 63664
(573) 438- 9355

Farmington Location:
508 West Pine St
Farmington, MO 63640
(573) 664-1100

School-Based Services
Call (573) GET-WELL
438-9355

Patient Registration Paperwork

<u>You will need to present a copy of the following at your First and Annual visits:</u>

- ☐ Driver's License or Photo Id
- ☐ Insurance Cards
- ☐ Signed Registration Forms
- ☐ Sliding Scale Application and income verification, if applicable
- ☐ Copays
- ☐ Proof of Address

Proof of Address: current utility bill, Piece of mail addressed to you (within 30 days), Paystub with current mailing address, any government mail (Social security, Pension etc.), lease or mortgage agreement.

Proof of Income: If you do **NOT** carry insurance or choose to not use your insurance please be sure to provide us with your proof of household income.

<u>Please provide all Household Income that applies:</u>

- ☐ Current Check Stub, W2, Current Tax Return, or
  company letterhead stating: Hourly rate of pay, gross pay and the pay period.
- ☐ Social Security, Child Support, SSI Disability award letter, or
  Food Stamp Summary (Must show total gross income)
- ☐ Current unemployment determination letter

Who does GMHC define as "Family/Household"?

- ☐ Husband, Wife and dependent Children (any age, related biologically or adopted)
- ☐ Significant Other
- ☐ Unmarried Partners
- ☐ Mother/Father if included on the tax return
- ☐ Grand Parents if included on the tax return
- ☐ Grand Children if included on the tax return
- ☐ All members included on the tax return

**I understand if I do not provide the above information within thirty (30) days from today, I will be fully responsible for all services rendered and these services will be billed at the full price until information is returned.*

<u>You will need to Present a copy of the following at the time of each visit:</u>

- ☐ <u>Driver's License or Photo Id</u>
- ☐ <u>Insurance Cards, if applicable</u>

Great Mines Health Center

REGISTRATION FORM

Please Print

Today's Date:	Preferred Provider:	Preferred Pharmacy:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Circle One: Mr. Mrs. Miss. Ms. Marital Status: Circle One Single / Mar / Div / Sep / Wid
Is this your legal name? Yes or No	If No, what is your legal name?		Former Name:
Date of Birth:MM/DD/YYYY	Age:	Sex at birth: M / F	Social Security Number:
Street Address: (PO Box)		City, State & Zip:	
Home Phone: ( )	Cell Phone: ( )	Email:	Contact Preference: Circle One Home / Cell / Email
Appointment reminders: Y / N Text: ______ Or email______	Driver License #		Driver License State:
Occupation:	Employer:		Employer Phone: ( )

Preferred Language: English, Spanish, other__________ **Race**: White, Black, Hispanic, other _____________

US Military Veteran: Y or N **Do you have an advanced directive:** Y or N

Sexual Orientation: Prefer not to disclose Lesbian/Gay/Homosexual/Straight/Heterosexual/Bisexual/Don't know

Gender Identity: Male/Female/Transgender Male/Female to Male Female/Male to Female

Housing Status: NOT Homeless/ Homeless/Public Housing/Doubling Up/Transitional Housing

Responsible Party Information

Responsible Party, First, M.I. and Last Name:	Date of Birth:	Relationship to Patient:	current patient? Y or N
Street Address, City, State & Zip: (If Different)			
Occupation:	Employer:	Employer Phone:	

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ **Dental Insurance** ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ **Dental Insurance** ☐ **Secondary** ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ **Dental Insurance** ☐ **Secondary** ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

EMERGENCY CONTACT

Name:	Relationship to Patient:	Home Phone:	Cell Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to GMHC. I understand that I am financially responsible for any co-pays and/or any remaining balance not paid by my insurance company. I also authorize Great Mines Health Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature	*Date:*

Revised 8-6-19

Consent and Authorization Form

Consent to Treatment

I hereby grant permission for Great Mines Health Center (GMHC) to perform those procedures and treatments deemed necessary or advisable for complete care of myself or a dependent for whom I am legally responsible. I authorize any GMHC licensed provider, or auxiliary to perform any treatment, medication administration and therapy that may be indicated in connection with my care or the care of my dependent. I understand that before treatment, full explanation of the procedure(s) involved will be given by staff.

Authorization and Release

I authorize GMHC to release any information, including the diagnosis and the records of any treatment or examination provided to me or my dependent during the period of such care, to third party payers and /or health practitioners. I understand this may include information regarding HIV, AIDS, Alcohol or drug abuse, mental illness or any mental health condition, sexually transmitted diseases, family planning, pregnancy, genetic tests or genetic diseases.

Persons Authorized to Receive Information:

Health information that Great Mines Health Center collects or receives about me may be disclosed to the following persons:

____

Name of Person **Relationship** **Phone Number**

____

Name of Person **Relationship** **Phone Number**

(Please Initial) GMHC representatives may leave a detail message on answering machine: Yes________ No________

(Please Initial) I authorize GMHC to release an excuse to my work/school: Yes________ No________

Financial Consent

I authorize and request my insurance company to pay directly to Great Mines Health Center. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services provided on my behalf or my dependents. If my account balance is sent to an outside agency for collection, I am responsible for collection fees that must be paid to said agency. *I am aware, that patients will be assessed a $25 fee for checks returned due to Insufficient Funds, a missed appointment fee of $5 for second missed appointment, $10 for third missed appointment, and $20 for each appointment missed thereafter for a three-year time period. Missed appointment fee will be charged if a 24-hour notice of cancellation is not given.* ***No controlled medication will be refilled if fee is not paid and patient will be walk-in only until fee is paid.***

Photographic Consent

I agree that photographs of me or my dependent may be taken by a member of Great Mines Health Center staff. The photograph(s) will be used for medical records and to help in the avoiding Identity Theft. All photographs are strictly private, and the identity of the patient will not be revealed to anyone outside of Great Mines Health Center unless required by law enforcement.

I further authorize, GMHC, to use radiographs, treatment records, and other diagnostic materials for the purpose of teaching, research, and scientific publications with the assurance that my or my dependent's identity will remain confidential. Opt out:_______

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. We are required by law to give you a copy of this notice, if requested. A copy of GMHC's HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. If you choose to receive information from Great Mines Health Center via email or text (e.g. appointment reminders), it will be sent through a secure server. However, you will be responsible for the protection of that information once it leaves our server. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

Patient's Name (please print) ____ Date Of Birth____________

Signature of patient or patient representative____

Print name and Relationship to Patient_____________________________________ Date__________________

***This signed consent, authorization and acknowledgment is effective until treatment is terminated in writing by you, the patient, or GMHC**

***IF APPLICABLE - School Based Clinic (SBHC) Location – additional consent to treatment, authorization and release**

I, the parent/guardian of said student, give consent for my child to receive services at GMHC SBHC. I understand that this consent form will be effective until my child leaves or graduates from the District, or until I provide the Center staff with written revocation of this consent. All healthcare information is confidential. By signing the consent form you are giving the SBHC and your child's regular doctor (if applicable) permission to communicate and share healthcare information regarding your child's medical, dental, or mental health, condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay at the time of service. I agree to all other terms listed as above. Confidentiality between the student, parents and the health center is assured. I understand that if guardianship changes a new consent must be signed by the legal guardian.

Signature:______________________________ **Date**______________ **School District SBHC:**______________________

Sliding Fee Discount Application

It is the policy of Great Mines Health Center to provide primary care services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside entities, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Please initial what applies to you:

1. _____ I am a new patient with GMHC, I do not have insurance and I did not bring my proof of income. This form serves as a Self-Statement of income for my first New-Patient visit only. *I am aware I have 30 days to return proof of income*
2. _____ I am an established patient at GMHC and recently lost my insurance coverage. This form serves as a Self-Statement of income for today's visit only. *I am aware I have 30 days to return proof of income*
3. _____ I have insurance but would like to submit this application for any services not covered by my insurance company and/or for services that I choose to not submit to my insurance company. *I am aware I have 30 days to return proof of income*

Head of Household: Yes or No Name of Head of Household ______________________________

Address:____
Street   City, State, Zip

Place of Employment:____

RELATIONSHIP	NAME	DATE OF BIRTH	PHONE	Currently a GMHC Patient Y/N
SELF				
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

Sliding Fee Discount Application

Annual Household Income – Based on Annual compensation

SOURCE	SELF	SPOUSE	DEPENDENT/OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business/self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL INCOME				

I, the person who has signed below, have filled out this application for the Sliding Fee Discount consideration and can prove that this information is true and correct, to the best of my knowledge. I am also aware that if there is any change in financial status of any of the people in my household it must be report immediately to Great Mines Health Center, (GMHC) and a new application must be filled out. I understand that, upon request of GMHC, and yearly, there will be a review of my application with the chance of discount amount changes. I understand that any untrue information written on form or the failure to provide proof of income within 30 days may result in my being made not qualified for the Discount Fee reduced priced made available by GMHC. I also understand this discount service is for services provided within GMHC only!

Applicants Signature:____ **Date:**________________

As a Federally Qualified Health Care Center we are required to collect certain information. The information on this form is used to determine the amount of discount that you may receive from GMHC and/or for statistical purposes. I understand that my personal or financial information will not be released.

BELOW TO BE COMPLETED BY GMHC STAFF ONLY

Witness By (GMHC Representative):____ Date:____________________

_________Approved__________% of discount Sliding Scale______________Annual Expiration Date:_________________

Provision, if any__________________proof of income Verified _______________30 day Expiration date:____________

_______Disapproved Reason:____

_______Pending Reason:____

Proof of Address Verified______________ Photo Id on File______________

Certified By:____ Date:_________________________

Great Mines Health Center

REGISTRATION FORM

Please Print

Today's Date:	Preferred Provider:	Preferred Pharmacy:

PATIENT INFORMATION

Patient's Last Name: First: Middle:			Circle One: Mr. Mrs. Miss. Ms. Marital Status: Circle One Single / Mar / Div / Sep / Wid
Is this your legal name? Yes or No	If No, what is your legal name?		Former Name:
Date of Birth:MM/DD/YYYY	Age:	Sex at birth: M / F	Social Security Number:
Street Address: (PO Box)		City, State & Zip:	
Home Phone: ( )	Cell Phone: ( )	Email:	Contact Preference: Circle One Home / Cell / Email
Appointment reminders: Y / N Text: ______ Or email______	Driver License #		Driver License State:
Occupation:	Employer:		Employer Phone: ( )

Preferred Language: English, Spanish, other__________ **Race**: White, Black, Hispanic, other _____________

US Military Veteran: Y or N **Do you have an advanced directive:** Y or N

Sexual Orientation: Prefer not to disclose Lesbian/Gay/Homosexual/Straight/Heterosexual/Bisexual/Don't know

Gender Identity: Male/Female/Transgender Male/Female to Male Female/Male to Female

Housing Status: NOT Homeless/ Homeless/Public Housing/Doubling Up/Transitional Housing

Responsible Party Information

Responsible Party, First, M.I. and Last Name:	Date of Birth:	Relationship to Patient:	current patient? Y or N
Street Address, City, State & Zip: (If Different)			
Occupation: Employer:		Employer Phone:	

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ **Dental Insurance** ☐

Name of Insured:		Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:		Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $		Rem. Deductible: $

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ **Dental Insurance** ☐ **Secondary** ☐

Name of Insured:		Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:		Group Number:	Policy Number:	
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Name of Insured:		Social Security:	Date of Birth:	Relationship to Patient:
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Employer Name:	Co-Payment: $	Rem. Benefits $		Rem. Deductible: $

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Name:	Relationship to Patient:	Home Phone:	Cell Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to GMHC. I understand that I am financially responsible for any co-pays and/or any remaining balance not paid by my insurance company. I also authorize Great Mines Health Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature	*Date:*

Revised 8-6-19

Consent and Authorization Form

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Authorization and Release

I authorize GMHC to release any information, including the diagnosis and the records of any treatment or examination provided to me or my dependent during the period of such care, to third party payers and /or health practitioners. I understand this may include information regarding HIV, AIDS, Alcohol or drug abuse, mental illness or any mental health condition, sexually transmitted diseases, family planning, pregnancy, genetic tests or genetic diseases.

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Health information that Great Mines Health Center collects or receives about me may be disclosed to the following persons:

____

Name of Person **Relationship** **Phone Number**

____

Name of Person **Relationship** **Phone Number**

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(Please Initial) I authorize GMHC to release an excuse to my work/school: Yes________ No________

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I further authorize, GMHC, to use radiographs, treatment records, and other diagnostic materials for the purpose of teaching, research, and scientific publications with the assurance that my or my dependent's identity will remain confidential. Opt out:_______

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Patient's Name (please print) ____Date Of Birth____________

Signature of patient or patient representative____

Print name and Relationship to Patient______________________________________ Date____________________

***This signed consent, authorization and acknowledgment is effective until treatment is terminated in writing by you, the patient, or GMHC**

***IF APPLICABLE - School Based Clinic (SBHC) Location – additional consent to treatment, authorization and release**

I, the parent/guardian of said student, give consent for my child to receive services at GMHC SBHC. I understand that this consent form will be effective until my child leaves or graduates from the District, or until I provide the Center staff with written revocation of this consent. All healthcare information is confidential. By signing the consent form you are giving the SBHC and your child's regular doctor (if applicable) permission to communicate and share healthcare information regarding your child's medical, dental, or mental health, condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay at the time of service. I agree to all other terms listed as above. Confidentiality between the student, parents and the health center is assured. I understand that if guardianship changes a new consent must be signed by the legal guardian.

Signature:________________________________ Date______________ School District SBHC:_______________________

Sliding Fee Discount Application

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The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside entities, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Please initial what applies to you:

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2. _____ I am an established patient at GMHC and recently lost my insurance coverage. This form serves as a Self-Statement of income for today's visit only. *I am aware I have 30 days to return proof of income*
3. _____ I have insurance but would like to submit this application for any services not covered by my insurance company and/or for services that I choose to not submit to my insurance company. *I am aware I have 30 days to return proof of income*

Head of Household: Yes or No Name of Head of Household ________________________________

Address:____
Street   City, State, Zip

Place of Employment:____

RELATIONSHIP	NAME	DATE OF BIRTH	PHONE	Currently a GMHC Patient Y/N
SELF				
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

Sliding Fee Discount Application

Annual Household Income – Based on Annual compensation

SOURCE	SELF	SPOUSE	DEPENDENT/OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business/self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL INCOME				

I, the person who has signed below, have filled out this application for the Sliding Fee Discount consideration and can prove that this information is true and correct, to the best of my knowledge. I am also aware that if there is any change in financial status of any of the people in my household it must be report immediately to Great Mines Health Center, (GMHC) and a new application must be filled out. I understand that, upon request of GMHC, and yearly, there will be a review of my application with the chance of discount amount changes. I understand that any untrue information written on form or the failure to provide proof of income within 30 days may result in my being made not qualified for the Discount Fee reduced priced made available by GMHC. I also understand this discount service is for services provided within GMHC only!

Applicants Signature:____________________________________ **Date:**______________

As a Federally Qualified Health Care Center we are required to collect certain information. The information on this form is used to determine the amount of discount that you may receive from GMHC and/or for statistical purposes. I understand that my personal or financial information will not be released.

BELOW TO BE COMPLETED BY GMHC STAFF ONLY

Witness By (GMHC Representative):________________________________ Date:____________

________Approved_________% of discount Sliding Scale___________Annual Expiration Date:____________

Provision, if any______________proof of income Verified ____________30 day Expiration date:__________

_______Disapproved Reason:____

_______Pending Reason:____

Proof of Address Verified____________ Photo Id on File____________

Certified By:____Date:______________

Pediatric Past Family and Social History
5 years and up

Date:______________**Patient Name:**______________________________**DOB:**______________**SEX:** □M □F

Date on Immunizations: Yes or No (Please make sure the office has an updated copy)

If not please state why: ____

Child Social History

Parent Information: *(circle all that apply)*

Parents together	Father Involved	Same Sex Partners
Parents separated	Mother Involved	Foster Care
Lives w/Mother	Father not Involved	Guardian Parents (Clarify):__________________
Lives w/Father	Mother not Involved	Other (Clarify): __________________

Is the patient adopted □ **Yes** □ **No** **Is the patient in foster care** □ **Yes** □ **No**

Parents Smoke: *(circle all that apply)* Yes No Outside Only

Pets (What Kind, How Many, Inside or Outside): ________________________________

Name of School/Preschool/Daycare: ________________________________

Has the patient ever received anesthesia □ **Yes** □ **No** **Any family history of anesthesia reactions** □ **Yes** □ **No**

Does the patient currently have an Epi Pen □ **Yes** □ **No** □ **Not Applicable**

Patient Medical History: Please circle Yes or No, if Yes please provide details

If the patient is adopted or in foster care please include any known medical history below

			Past or Current Diagnosis	Physician Name or Name of Facility
Cancer	No	Yes		
Blood Disorder	No	Yes		
Diabetes	No	Yes		
Endocrine/Metabolic Disorder	No	Yes		
Ear, Nose, & Throat Disorder	No	Yes		
Cardiovascular Disorder	No	Yes		
GI/Stomach Disorder	No	Yes		
GU/Kidney Disease	No	Yes		
Musculoskeletal Disorder	No	Yes		
Neurological Disorder	No	Yes		
Psychiatric/Learning Disorder	No	Yes		
Respiratory/Asthma Disorder	No	Yes		
Skin Disease	No	Yes		
Other Chronic Problems	No	Yes		

Pediatric Past Family and Social History
5 years and up

MEDICATIONS: **Does the patient currently take any medications □ Yes □ No**
If you marked Yes, please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc

Medication	Dosage	Directions/ Frequency	Medication	Dosage	Directions/Frequency
1.			4.		
2.			5.		
3.			6.		

HOSPITALIZATONS: **Has the patient ever been hospitalized □ Yes □ No**
If you marked Yes, please list the dates, the name of the hospital, the reason and how long they were there

Date (Month, Day, Year)	Hospital Name	Reason or Diagnosis	How long where they there

SURGICAL PROCEDURES: **Has the patient had any previous surgeries □ Yes □No**
If you marked Yes, please list the date of the surgery, name of the hospital where it was performed and the name of the procedure

Date (Month, Day, Year)	Hospital Name	Surgical Procedure	Date (Month, Day, Year)	Hospital Name	Surgical Procedure
1.			4.		
2.			5.		
3.			6.		

ALLERGIES: **Does the patient have any known allergies □ Yes □ No**
If you marked Yes, please list the date they were diagnosed, allergy name and the reaction type

Date (Month, Day, Year)	Allergy Name	Reaction (Ex: anaphylactic shock, rash, diarrhea)	Severity (Ex: Mild, Moderate, Severe)

Does the patient currently have an Epi Pen □ Yes □ No □ Not Applicable

Dental History: Name of Dentist:____Date of last exam: ______________

Vision History: Name of eye care facility:_______________________________________Date of last exam:_______________
Currently wear glasses/contacts: □Yes □No

Pediatric Past Family and Social History
5 years and up

Education/School/Social History:

Name of School: ______________________________ **Grade:** ______________________

School Performance: *(circle all that apply)*

Likes School   Dislike School   Advanced Program   Honor Roll

Excellent   Good Grades   Grades are declining   Struggling to keep up

School Issues/Concerns: *(circle all that apply)*

None   Behavior Problems   Non Attendance   Expelled   Suspended

Peer Interactions: *(circle all that apply)*

Makes friends easily   Has good group of friends   Tends to keep to self   Fights with other children

Has trouble making/keeping friends   Bullied/picked on by other children   Bossy/picks on other children

Extracurricular Activities: *(circle all that apply)*

Baseball/Softball   Basketball   Soccer   Martial arts   Dance/cheer   Plays musical instrument

Sings in choir   Art or drama   Scouts   Church group   Gymnastics   Taekwondo   Track/Cross Country

Other: ______________________________
Does the patient currently receive any academic assistance at school □ Yes □ No if Yes please provide details

____

Menstrual History: (Only required for Adolescent girls)

Has the patient started her period □ Yes □ No (if yes please answer the questions below)
What age did the patient start:______________**Is the cycle regular or irregular**: ______________
How long does the cycle last:______________**How is the flow (Excessive, Heavy, Minimal)**:______________

Smoking Status: (Only required for patient 13 years and older)

Is the patient a former or current smoker □ Yes □ No (if yes please answer the questions below)
Does or did the patient smoke light, hand-rolled, natural, or herbal cigarettes □ Yes □ No
How many per day or how many packs:______________Age started______________Age stopped ______________
Does or did the patient smoke Bidis(flavored cigarettes), Clove cigarettes (Kreteks) □ Yes □ No How many per day or how many packs:______________Age started______________Age stopped ______________
Does or did the patient smoke cigars, little cigars, Cigarillos, or Blunts □ Yes □ No
How many per day or how many packs:______________Age started______________Age stopped______________
Does or did the patient smoke a pipe, water pipe or Hookah □ Yes □ No
How many pipes a day:______________Age started______________Age stopped ______________
Does or did the patient smoke a Electronic Cigarettes or E-Cigarettes □ Yes □ No
How many per day or how many packs:____Age started___Age stopped ______________ **Does or did the patient use Smokeless Tobacco, Chew Tobacco, Snuff, and Snus □ Yes □ No** How many times per day:______________Age started______________Age stopped __

Sexual History: (Only required for Adolescent patient)
Is the patient currently sexual active □ Yes □ No (if yes please answer the questions below) **How many sexual partners have they had:**______________**Do they use protection:** ______________
Has the patient ever had an STD (Sexual Transmitted Disease) □ Yes □ No
GIRLS: Is the patient on birth control □ Yes □ No

Pediatric Past Family and Social History
5 years and up

FAMILY HISTORY: Please indicate with a check (√) if the patient's family has had any of the following conditions and then specify in the box their diagnosis. In the second column please indicate their living status. L = Living, D = Deceased, U = Unknown. **If the patient is adopted or in foster care please include any known family medical history below**

	Date of Birth	Living Status	Cancer	Diabetes	Heart Disease	Eye Disorder	Ear Disorder	Respiratory Disorder	GI Disorder	GU Disorder	Muscle Disorder	Neurological Disorder	Psychiatric Disorder	Skin Disease
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandma			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandpa			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandma			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandpa			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please list any other family medical history:

History Completed By: ______________________________