Pediatric Wellness
Of Northern New York
19474 Howell Drive, Watertown, NY 13601
Phone: (315) 782-7330 Fax: (315) 782-5773
pediatricwellnessnny.com

PATIENT REGISTRATION FORM

Patient Name: _____ DOB: _____
Patient Address: _____
Patient SS #: ___-___-___. __ Male. __ Female Gender Identity (optional): _____
Race (optional) __ American Indian/Alaskan Native __ Asian __ Black/African American __ White
__ Hawaiian/Pacific Islander __Other. __Decline/Refuse to Answer/Unknown
Ethnicity: __ Hispanic __Non-Hispanic Primary Language: _____

Parent / Guardian Demographics

Mother's Name:_____ Father's Name: _____
Address: _____ Address: _____
DOB: _____ SSN#:_____ DOB: _____ SSN#: _____
Phone Number : _____ Phone Number: _____
Email: _____ Email: _____

Legal Guardian Name (if other than biological parents) :_____
Address: _____ Phone Number: _____
Emergency Contact: _____ Phone Number: _____
Email for portal use: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Effective Date: _____
Policy Holder :_____ DOB: _____ Employer: _____
Secondary Insurance :_____ ID#: _____ Effective Date: _____

Acknowledgement of Receipt of Privacy Practices

I, _____ have read PEDIATRIC WELLNESS OF NORTHERN NEW YORK PLLC Notice of Privacy Practices effective April 14, 2023.

Signature: _____ Date: _____

Understanding Your Insurance and Care

Your health insurance plan does not automatically cover every healthcare cost or service.

- **Coverage Limits**: Insurance only pays for items and services explicitly defined as "covered" in your specific policy.
- **Your Responsibility**: You are responsible for knowing what your plan covers. Medical offices do not have access to your specific contract details.
- **Finding Information**: You can find your covered benefits by reviewing your health insurance contract or calling your insurance provider directly.
- **Doctor Recommendations**: A medical recommendation from your physician does not guarantee insurance coverage. You may still need a service even if your insurance refuses to pay for it.

Signature: _____ Date: _____

Pediatric Wellness of Northern New York PLLC Authorization and Policies

- I authorize the release of any medical or necessary information to the insurance company to process any insurance claims.
- I authorize payments of medical benefits to PEDIATRIC WELLNESS OF NOTHERN NEW YORK PLLC
- I authorize PEDIATRIC WELLNESS OF NORTHERN NEW YORK PLLC to provide medical treatment to my child
- I authorize the release of my child's immunization records and physical exams to his/her school per my request
- I give PEDIATRIC WELLNESS OF NORTHERN NEW YORK PLLC permission to send out my child's culture and nasal swabs to Samaritan Medical Center, 830 Washington st., Watertown NY 13601 for testing.
- I understand that three (3) or more missed appointments may lead to dismissal.
- I understand that a parent or guardian must always be present at the time of appointment for ages under 18 years.

Signature: _____ Date: _____

OFFICE USE VERIFIED BY: _____ DATE: _____

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PERMISSION FOR TREATMENT OF MINOR

Parent's/Legal Guardian Name : _____ Phone #: _____
Address: _____ Emai: _____
Child's Name: _____ DOB: _____
I, _____ authorize the names mentioned below to act on my behalf in my absence for the patient listed above:

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

DATES OF AUTHORIZATION

__ Indefinitely OR Beginning: ___/___/_____ Ending: ___/___/_____

CHECK ALL THAT APPLY

__ Treatment __ Prescriptions __ Appointment Scheduling __ Vaccine __ Records __Payments
__ Other: _____

Signature: _____ Date: _____
Witness: _____ (Must be verified by office staff)

Please remember to have above mentioned authorized person to bring photo ID and patient's Insurance Card

AHC Health Related Social Needs Screening Questions	
Housing/ Utilities	
1. What is your living situation today?	☐ I have a steady place to live ☐ I have a place to live today, but I am worried about losing it in the future ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	☐ Pests such as bugs, ants, or mice ☐ Mold ☐ Lead paint or pipes ☐ Lack of heat ☐ Oven or stove not working ☐ Smoke detectors missing or not working ☐ Water leaks ☐ None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	☐ Yes ☐ No ☐ Already shut off
Food Security	
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	☐ Often true ☐ Sometimes true ☐ Never true
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	☐ Often true ☐ Sometimes true ☐ Never true
Transportation	
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	☐ Yes ☐ No
Employment	
7. Do you want help finding or keeping work or a job?	☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help
Education	
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	☐ Yes ☐ No
Interpersonal Safety Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.	A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe
9. How often does anyone, including family and friends, physically hurt you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
10. How often does anyone, including family and friends, insult or talk down to you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
11. How often does anyone, including family and friends, threaten you with harm?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
12. How often does anyone, including family and friends, scream or curse at you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)

CHART #

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____Age _____ Male _____ Female _____

Mother's Name _____ Father's name _____

Form filled out by _____ Date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications _____

Delivery by ☐vaginal ☐c-section

Reason for c-section _____

Complications _____

Was your child premature ☐No ☐Yes, born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease _____
- ☐Wheezing or bronchiolitis _____
- ☐ Seasonal allergies or eczema _____
- ☐ Food allergy _____
- ☐ Recurrent ear infections _____
- ☐ Pneumonia _____
- ☐ Urinary tract infections _____
- ☐ Genetic syndrome _____
- ☐ Seizures _____
- ☐ Anemia _____
- ☐ Broken bone _____
- ☐ Mental retardation or learning disability _____
- ☐ Depression/anxiety _____

Other chronic medical conditions _____

_____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

_____

_____

Previous surgeries and dates _____

_____

Previous pediatrician _____

Please list any specialist your child is currently seeing and reason:

_____

_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

_____

_____

Current medications and dose: _____

_____

_____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Development/Nutrition

At what age did your child:

Walk alone _____ Sit alone _____

Toilet train(day) _____ Say words _____

1st period (females) _____

Was your child breastfed ☐ No ☐Yes, how long? _____

Has your child had any unusual feeding/dietary problems? Explain.

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____

☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Mother's occupation _____

Father's occupation _____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

School's name _____ Grade _____

Any concerns about school performance? ☐ No ☐ Yes, explain

_____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____Computer _____Video games _____

Sports/exercise: Type _____

How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____

_____

_____

_____

Review of Systems (*Check all that apply*)

Constitutional
- ☐ Fever, chills ☐ Fatigue
- ☐ Unexplained weight loss/gain
- ☐ Excessive thirst

Ear, Nose, and Throat
- ☐ Loud voice, hearing problem
- ☐ Mouth-breathing, snoring
- ☐ Ear pain
- ☐ Frequent runny nose

Respiratory
- ☐ Cough, short of breath
- ☐ Chest tightness, wheeze

Musculoskeletal
- ☐ Muscle pain, weakness
- ☐ Joint pain, swelling
- ☐ Bone pain

Other (eye,skin,blood)
- ☐ Blurry vision ☐ Squinting
- ☐ "Crossed" eyes ☐ Itchy eyes
- ☐ Rashes ☐ Abnormal moles
- ☐ Abnormal bruising, bleeding

Gastrointestinal
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation, blood in stool
- ☐ Abdominal pain

Cardiovascular
- ☐ Chest pain, palpitations
- ☐ Tires easily with exertion
- ☐ Fainting

Genitourinary
- ☐ Frequent or painful urination
- ☐ Bedwetting, frequent accidents
- ☐ Vaginal or penile discharge

Neurologic
- ☐ Headaches ☐ Seizures
- ☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
- ☐ Anxiety/stress ☐Depression
- ☐ Sleep problem ☐ Anger concern
- ☐ Concerns with attention, impulsivity

Reviewed by _____***MD*** ***date*** _____