COMPREHENSIVE PEDIATRICS, PC

NEWBORN • INFANT • PEDIATRIC • ADOLESCENT MEDICINE

WWW.COMPREHENSIVEPEDIATRICSNY.COM

REQUEST FOR TRANSFER OF MEDICAL RECORDS

DATE:_____

TO: Doctor's Name:_____
Facility Name:_____
Address: _____
City: _____ State:____ Zip:_____

From:

☐ COMPREHENSIVE PEDIATRICS
4982 HYLAN BLVD.
STATEN ISLAND, NY 10312
TEL: 718-967-6200
FAX: 718-967-6314

☐ COMPREHENSIVE PEDIATRICS
1407 WEST 6TH ST.
BROOKLYN, NY 11204
TEL: 718-236-6994
FAX: 718-331-3871

☐ COMPREHENSIVE PEDIATRICS
1145 TARGEE ST.
STATEN ISLAND, NY 10304
TEL: 718-351-3484
FAX: 718-351-3149

I hereby consent the release of my child's complete medical record and immunization history to Comprehensive Pediatrics at the above marked address.

Thank you, your prompt attention to this matter is greatly appreciated.

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

_____ Parent's Name (Print)

_____ Parent's Signature

_____ Date

COMPREHENSIVE PEDIATRICS, PC

TODAY'S DATE _____

☐ NEW PATIENT

☐ UPDATED INFORMATION

ACCT#_____

VFC: ☐ YES ☐ NO

HOW DIDYOU HEAR ABOUT US?

☐ A1. PHYSICIAN: NAME: _____
☐ OB/GYN ADDRESS: _____
☐ OTHER DR. TEL: _____
☐ A2. HOSPITAL NAME: _____
☐ A3. INSURANCE COMPANY ☐ A4. FRIEND/RELATIVE ☐ A5. YELLOW PAGES
☐ A6. NEWSPAPER ☐ A7. VALPAK ☐ A8. INTERNET
☐ A9. OTHER _____ Your E-Mail: _____

Please Print

PATIENT INFORMATION

Patient's Name _____
As It Appears on Insurance Card Last First Mi

Male ☐ Female ☐ Date of Birth _____ (MM DD YYYY) Age _____ TODAY

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR COMPREHENSIVE PEDIATRICS TO BILL YOUR INSURANCE COMPANY

PRIMARY INSURANCE CARRIER

Insurance
Carrier Name _____

Policy
Holder Name _____

ID # _____

Group Number _____

Date Insurance Began _____

☐ HMO ☐ PPO ☐ EPO ☐ Other

Copay _____ Annual Deductible _____

SECONDARY INSURANCE CARRIER

Insurance
Carrier Name _____

Policy
Holder Name _____

ID # _____

Group Number _____

Date Insurance Began _____

☐ HMO ☐ PPO ☐ EPO ☐ Other

Copay _____ Annual Deductible _____

PLEASE REMEMBER TO HAVE YOUR INSURANCE CARD AT EVERY VISIT

PARENT'S INFORMATION

Mother's Name _____
Last First Mi

Social Security Number _____

Birthdate _____

Address _____ Apt# _____

City _____ State ____ Zip _____

Phone Numbers: Home _____
Work _____
Cell _____

Employer's Name _____

Address _____ Apt# _____

City _____ State ____ Zip _____

Father's Name _____
Last First Mi

Social Security Number _____

Birthdate _____

Address _____ Apt# _____

City _____ State ____ Zip _____

Phone Numbers: Home _____
Work _____
Cell _____

Employer's Name _____

Address _____ Apt# _____

City _____ State ____ Zip _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, _____ , acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Comprehensive Pediatrics. I understand that I am responsible for meeting my insurance deductibles and coinsurance and any noncovered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Comprehensive Pediatrics.

Signature _____ Date _____

TODAY'S DATE _____

☐ NEW PATIENT

☐ UPDATED INFORMATION

ACCT#_____

VFC CODE: ☐ Yes ☐ No

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Please Print

PATIENT MEDICAL HISTORY

Patient's Name _____
As It Appears on Insurance Card — Last — First — Mi

Male ☐ Female ☐ Date of Birth _____ (MM DD YYYY) Age _____ TODAY

GENERAL MEDICAL INFORMATION

PRESENT HEALTH CONCERNS: _____

MEDICINES VITAMINS: _____

ALLERGIES TO MEDICATIONS/VACCINES: _____

PREVIOUS PEDIATRICIAN, OTHER PHYSICIAN(S) TREATING YOUR CHILD: _____

PREGNANCY & BIRTH

IS THIS CHILD YOURS BY: ☐ BIRTH ☐ STEPCHILD ADOPTION

OTHER: _____

ANY PROBLEMS DURING PREGNANCY: ☐ NO ☐ YES

PLEASE EXPLAIN: _____

DELIVERY TYPE: ☐ VAGINAL BIRTH ☐ CAESARIAN

PLEASE EXPLAIN: _____

MEDICAL PROBLEMS DURING BABY'S NEWBORN PERIOD. ☐ NONE
IF PREMATURE, HOW EARLY?

BIRTH WEIGHT: _____ BIRTH HEIGHT: _____

HOSPITAL: _____ OBGYN: _____

NUTRITION & FEEDING

WAS YOUR CHILD BREASTFED? ☐ NO ☐ YES, HOW LONG? _____

DOES YOUR CHILD HAVE ANY UNUSUAL FEEDING/DIETARY PROBLEMS? ☐ NO ☐ YES

IF YES, EXPLAIN: _____

SLEEP

HOURS PER NIGHT: _____ NAPS (NUMBER & LENGHT): _____

ANY SLEEP PROBLEMS: _____

DEVELOPMENT

AT WHAT AGE DID CHILD: SIT ALONE: _____ WALK ALONE: _____

SAY WORDS: _____ TOILET TRAIN: _____

GIRLS ONLY: AGE AT FIRST MENSTRUAL PERIOD: _____

IMMUNIZATIONS

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? ☐ NO ☐ YES

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASE:

☐ CHICKEN POX ☐ MEASLES ☐ MUMPS
☐ RUBELLA ☐ MENINGITIS ☐ TUBERCULOSIS (TB)

PLEASE BRING CHILD'S VACCINE RECORDS

EXPOSURE & HABITS

ANY CONCERNS ABOUT LEAD EXPOSURE? (OLD HOME/PLUMBING/PEELING PAINT) ☐ NO ☐ YES

DO ANY HOUSEHOLD MEMBERS SMOKE? ☐ NO ☐ YES

TV - HOURS PER DAY _____ COMPUTER - HOURS PER DAY: _____

VIDEO GAMES - HOURS PER DAY _____

SPORTS/EXCERCISE: TYPE: _____

HOW OFTEN? _____ HOW LONG? _____

PAST MEDICAL HISTORY

☐ ASTHMA / HAY FEVER / ECZEMA
☐ FREQUENT EAR INFECITONS
☐ ATTENTION PROBLEMS
☐ PROBLEMS GOING POTTY
☐ URINARY TRACK INFECTION
☐ RSV
☐ BROKEN BONES
☐ CHICKEN POX
☐ ANEMIA
☐ PNEUMONIA
☐ CROUP
☐ OBESITY

OTHER: _____

HOSPITALIZATION/OPERATIONS (WITH DATES): _____

BROKEN BONE/SEVERE SPRAINS _____

DENTAL HISTORY

HAS CHILD BEEN SEEN BY A DENTIST ? ☐ NO YES, HOW OFTEN? _____

LAST VISIT _____

FAMILY HISTORY

PLEASE INDICATE DEATHS OF IMMIDIATE FAMILY MEMBERS: _____

PLEASE INDICATE FAMILY MEMBERS WITH ANY OF THE FOLLOWING CONDITIONS:
(FATHER, MOTHER, BROTHER, SISTER, GRANDMOTHER, GRANDFATHER, AUNT, UNCLE)

ALOHOLISM: _____

HIGH CHOLESTEROL: _____

CANCER, SPECIFY: _____

HIGH BLOOD PRESSURE: _____

HEART DISEASE: _____

STROKE: _____

DEPRESSION/SUICIDE" _____

BLEEDING OR CLOTTING DISORDER: _____

GENETIC DISORDERS: _____

ASTHMA/COPD: _____

DIABETES: _____

OTHER: _____

SOCIAL HISTORY

WHO LIVES AT HOME?

NAME	AGE	RELATIONSHIP	HIGHEST EDUCATION LEVEL

ARE CHILD'S PARENTS: ☐ MARRIED ☐ UNMARRIED ☐ SEPARATED ☐ DIVORCED

IF DIVORCED OR SEPARATED, WHEN? _____

CHILD CARE SITUATION: ☐ PARENTS OTHER, WHO? _____

CONCERNS ABOUT CHILD: ☐ ALCOHOL USE ☐ TOBACCO ☐ SEXUAL ACTIVITY ☐ AGGRESIVE BEHAVIOR

IS VIOLENCE AT HOME A CONCERN? ☐ NO ☐ YES

ARE THERE GUNS AT HOME? ☐ NO ☐ YES

SCHOOL HISTORY

DID/DOES YOUR CHILD ATTEND SCHOOL OR PRESCHOOL? ☐ NO YES, GRADE? _____

NAME OF SCHOOL: _____

ANY CONCERNS ABOUT RELATIONSHIP WITH: TEACHERS ☐ NO ☐ YES
PEERS ☐ NO ☐ YES