CUMBERLAND FAMILY CARE, PC
Patient Information/Consent for Treatment, Payment, and Daily Operations (please print)

Name____Date_________________
Last First Middle

Address_______________________________ Home _____________Work ___________________
(Phone)

__________________________________ Cell __________________Carrier_________________
City State Zip (Cell Phone)

Date of Birth ___________________Age_____

SS # _________________________

Please Circle One for 1-4 below:

1. Race: (White) (Black) (Hispanic) (Other)____________________
2. Is English You Primary Language: **(**Yes) or (No) If no, what language_________________
3. Sex: Male Female
4. Marital Status: Single Married Divorced Widowed Other_____________

E-mail address: ____

Insurance Plan Information
Please present card at reception
<u>Person responsible for the bill if other than information provided above:</u>

Name_____________________________________Relationship_____________________________

Address____Phone____________________________

<u>Emergency Contact Information</u>

Name____ Relationship to patient___________________

Phone:______________________ Cell _____________________ Work _________________________

<u>Authorizations</u>

<u>I understand</u> that I am financially responsible for services rendered by the physician and his staff regardless of insurance, including reasonable attorney's fees and costs of collection in the event of default. I authorize my insurance company to pay benefits directly to the physician.
<u>If applicable: I give consent</u> for the above patient, who is either under the age of 18 or requires a legal custodian, to receive any treatment that is deemed necessary by Cumberland Family Care, PC.
<u>I understand all of the above</u> and hereby state that the information is correct to the best of my knowledge. These authorizations apply to all occasions until revoked. My signature indicates that I have read the above and grant to request of authorizations. I give my consent for disclosure of my protected health information for purposes of treatment, payment, daily operations and other disclosures as specifically listed on the Notice of Privacy Practices posted in the lobby of Cumberland Family Care, PC.

Signature____ **Date**_________________________

Personal History for Children

Name:____**Date:**________________

Prenatal Problems: List any problems that occurred while this child's mother was pregnant:

____

____

____

Problems at Birth: List any problems that occurred with this child at birth/shortly afterward:

____

____

____

Birth Weight**:** ___lbs ___oz Doctor Delivering Child:________________ Hospital: ________________

Childhood Illnesses (circle): Measles, Mumps, Chicken Pox, Rubella (German Measles), RSV, Croup

Major Illnesses: Check any major diseases this child has/has had:

	Pneumonia		Anemia		Colitis		Hives
	Influenza		Jaundice		Bowel Disease		Eczema
	Rheumatic Fever		Bladder Disease		Food Poisoning		Frequent Infection
	Heart Trouble		Epilepsy		Drug Poisoning		Frequent Boils
	Arthritis		Migraine Headaches		Other Poisoning		Behavior Problems
	Polio		Tuberculosis		Hay Fever		Nephritis
	Meningitis		Diabetes		Asthma		Mumps
	Ear Infections	-	How Many?		Measles		

Other Illness: Indicate all other illnesses this child has had.

____

____

Injuries: Has this child had any:

Broken/cracked bones (five bone and date):____

Severe sprains/dislocations (give joint and date):____

Concussion, head injury or loss/been unconscious:____

Surgeries: List all operations/surgeries (tonsils, appendix) and this dates:

____

____

Hospitalizations: Has this child ever been hospitalized for any illness? Give date and details:

____

____

Mental Health: Has this child ever:

Been hospitalized for mental illness? ____

Seen a psychiatrist/counselor? ____

Been a ward of the state or in foster care?____

Previous Family Doctor(s):____

Consultants/Specialists: List any other doctors who provide medical care for child:___________________

____

Dentist:____

Social History

Guardian of child:____
Marital status of parents of child: Married / Divorced / Separated / Never Married
Father:______________________________ Father's Residence:______________________________
Mother:_____________________________ Mother's Residence:_____________________________
Adults that child lives with (if other than parents):____
Caretakers:____
Occupations of parents/guardians:____
Names of siblings of child:____
Other children living in house:____
Family Religion:______________________________ Congregation:___________________________

Family Health Habits

How many smokers live with this child?:_____
Alcoholism in the immediate family?_____ Which family member(s)?________________________
Is the family on a low cholesterol diet?_____
Dose this child get regular exercise?_____ What type?____________________________________
What type of water does the family drink? Well / City / Bottled
What type of structure does child live in? Apartment / House / Trailer How old is it?_____
What city/community does child live in?____
Hobbies/interests?____
What is child interested in?____
Pets in home?_____ Pets outside home?_____