Lake Norman Pediatrics

Chart#

PATIENT INFORMATION

____ _______________ **Sex:** ☐ M ☐ F
Patient Name – First, Middle, Last   Name Called

____
Street Address or PO Box: City State ZIP Code

____________ ________________ ______________
Date of Birth Patient SS# Home Phone Number

Primary Contact:________________ ____________ ____________ ____________
Name Cell# Work# Home#

****Primary contact will be used for Appointment scheduling, cancellations, lab results, etc.****

CONTACT INFORMATION OR LEGAL GUARDIAN

☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Legal Guardian- Relationship__________________________

____ __________________
First, Middle Init, Last Date of Birth

______________ ___________________ ___________________
SS# Home Phone# Cell #

____
Street Address or PO Box: City State ZIP Code

_______________________ ___________ _________________________________
Place of Employment: Work Phone # Parent/Guardian E-Mail Address

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☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Legal Guardian- Relationship__________________________

____ __________________
First, Middle Init, Last Date of Birth

______________ ___________________ ___________________
SS# Home Phone# Cell #

____
Street Address or PO Box: City State ZIP Code

_______________________ ___________ _________________________________
Place of Employment: Work Phone # Parent/Guardian E-Mail Address

INSURANCE INFORMATION

________________________________ ___________________ ____________________
Primary Insurance Company Policy Holders Name SS#

We file all Primary Insurances

We file Seconday insurance only with BC/BS, Tricare and Medicaid

A copy of insurance cards are required to file insurance

Copay is required at time of service

__________________________________ ____________
Signature of Parent/Legal Guardian Date

Lake Norman Pediatrics

Chart#

PATIENT HISTORY FORM

____ ____________ **Sex:** ☐ M ☐ F
Patients Name – First Middle Last Date of Birth

Allergies:
Drug ____Reaction______________________________

Food____Reaction______________________________

Environmental Allergies___________________________ Reaction______________________________

☐ No Known Allergies – Date ____________

Does anyone smoke in the household? ☐ Yes ☐ Outside Only ☐ No

OTHER CHILDREN IN FAMILY

Name:________________________ Name:_________________________ Name:________________________

Name:________________________ Name:_________________________ Name:________________________

PLEASE CHECK – PATIENT HISTORY

☐ Anemia
☐ Asthma
☐ Cancer
☐ Chicken Pox
☐ Delayed Development
☐ Diabetes
☐ Ear Infections
☐ Feeding Problems
☐ Hearing Impairment
☐ Heart Condition
☐ Kidney Problems
☐ Leukemia
☐ Prematurity
☐ Speech Impairment
☐ Strep Throat
☐ Tonsillitis
☐ Wheezing
☐ Other ___________________

List Surgeries/Hospitalizations:____

IMMUNIZATIONS- A copy of your child's immunization record is required

PLEASE CHECK – FAMILY HISTORY /RELATIONSHIP TO PATIENT

☐ Allergies __________
☐ Anemia ___________
☐ Asthma ___________
☐ Cancer ___________
☐ Diabetes________________
☐ Heart Condition___________
☐ High Blood Pressure_________
☐ High Cholesterol__________
☐ Kidney Problems ___________
☐ Lung Problems ____________
☐ Other ________________________

BIRTH HISTORY

Location: ____________________________ Pediatrician:_________________

Birth Weight:__________Length________ ☐ Breastfed ☐ Formula _____________Oxygen Required ☐ Yes

Complications:____

SOCIAL HISTORY

Parent Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated

Who has legal custody of child? ☐ Mom ☐ Dad ☐ Grandparents ☐ Other _________________________

Who will bring child to the office? (Check all that apply) ☐ Mom ☐ Dad ☐ Grandparents ☐ Stepmom
☐ Stepfather ☐ Other _______________________

656 Carpenter Avenue
Mooresville, NC 28115
704-664-5133
FAX 704-660-0406

Providing Comprehensive Pediatric Care for Your Children from Birth through Adolescence Since 1987

PRIVACY FORMS

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Acknowledgement of Receipt of the Notice of Privacy Practices — *F-2000*

____ ____________________
Name of Patient (*Please Print or Type*) Patient Date of Birth

I acknowledge I was provided of the Notice of Privacy Practices of Lake Norman Pediatrics. The Notice of Privacy Practices provides information about how Lake Norman Pediatrics may use and disclose protected health information on the patient listed. I was given the opportunity and encouraged to read it in full.

Lake Norman Pediatrics reserves the right to revise its Notice of Privacy Practices. If the notice is modified, a copy of the revised notice may be obtained by:

- requesting a copy in person
- accessing the Lake Norman Pediatrics web site at http://www.lakenormanpediatrics.com
- requesting a copy be mailed

If you have any questions about the Lake Norman Pediatrics Notice of Privacy Practices, please contact:

Lake Norman Pediatrics
Attn: Privacy Administrator
656 Carpenter Avenue
Mooresville, NC 28115
704-664-5133

Required Signature

____
Signature of Patient or Patient Representative

____ ____________________
Name of Patient Representative and Relationship (*Please Print or Type*) Date

INABILITY TO OBTAIN ACKNOWLEDGEMENT

A good faith effort was made to obtain an acknowledgement that the Lake Norman Pediatrics Notice of Privacy Practices was provided to the patient listed above or their representative. The acknowledgement was not obtained because:

- ❑ The patient was undergoing emergency treatment
- ❑ The patient or patient representative declined to sign the acknowledgement
- ❑ Other: ________________________________

Required Signature

____
Name of Staff Member (*Please Print or Type*)

____ ____________________
Signature Date