FAMILY INFORMATION SHEET

12CP Doctor: ____

Parent/Legal Guardian #1: **Primary responsible party living in same household as child(ren) who will be listed as Portal Representative and receive *automated* mail and phone correspondence

Name: ____ **DOB**: _______________ Relationship to Patient: ________________
Home Phone Number: ____________________________ Cell Phone Number: __________________________________
Work Phone Number: ____________________________ E-Mail: ____
Address: ____
Street City State Zip
Employer: ___________________________________ Occupation: ____

Parent/Legal Guardian #2:

Name: ____ **DOB**: _______________ Relationship to Patient: ________________
Home Phone Number: ____________________________ Cell Phone Number: __________________________________
Work Phone Number: ____________________________ E-Mail: ____
Address: ____
Street City State Zip
Employer: ___________________________________ Occupation: ____

Other Information:

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

Preferred Pharmacy (please be location specific):____

Enrolled in an ACO: ☐ AHP ☐ GRIPA

Emergency Contact (other than parents):____ Phone: _________________________

Patient(s) Information:

Race: ________________________ Ethnicity: ☐ Hispanic or ☐ Not Hispanic Language: __________________________

Child's Name:___________________________________ DOB:______________ E-Mail (18+ yrs): __________________________
Address (Please choose): ☐ Same as Parent/Legal Guardian #1 Cell (18+yrs): __________________________
☐ Other ____

Child's Name:___________________________________ DOB:______________ E-Mail (18+ yrs): __________________________
Address (Please choose): ☐ Same as Parent/Legal Guardian #1 Cell (18+yrs): __________________________
☐ Other ____

Child's Name:___________________________________ DOB:______________ E-Mail (18+ yrs): __________________________
Address (Please choose): ☐ Same as Parent/Legal Guardian #1 Cell (18+yrs): __________________________
☐ Other ____

Child's Name:___________________________________ DOB:______________ E-Mail (18+ yrs): __________________________
Address (Please choose): ☐ Same as Parent/Legal Guardian #1 Cell (18+yrs): __________________________
☐ Other ____

I authorize payment of medical benefits to the above named physician. I also agree to the release of any pertinent medical information necessary to expedite insurance payment. I also authorize insurance companies to review my health record for quality reporting.

Signed: ____ Date: __________________________________

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FAMILY HISTORY SHEET

Family Last Name: _____
Each Child's First Name in Family: _____

Other Heath Care Providers (for the children, not the parents):

FULL Name of Provider: For which Children:

Dentist: _____

Behavioral Health: _____

Other: _____

Other: _____

FAMILY MEDICAL HISTORY

(as it pertains to your child; your child's mother, your child's Maternal Grandfather, etc.)

☐ **UNKNOWN / ADOPTED** ☐ **No Significant Family History**

Medical Condition	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other (Please Specify)
Alcoholism							
Allergies							
Anemia							
Anxiety							
ADHD							
Autism							
Cancer							
Celiac Disease							
Depression							
Diabetes							
Down Syndrome							
Epilepsy							
Heart Disease							
Hypercholesterolemia							
Inflam. Bowel Disease							
Kidney Disease							
Liver Disease							
Mental Illness							
Obesity							
Substance Abuse							
Thyroid Disease							
Other:							
Other:							
Other:							

Smoking in Family:

☐ **No** ☐ **Quit** ☐ **Yes** **who: _____**

Signed: _____ Date: _____

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