

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:

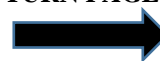
Parent Marital Status: [] Single [] Married [] Divorced [] Widowed [] Separated [] Partners
Preferred Pharmacy (please be location specific): _____
Enrolled in an ACO: [] AHP [] GRIPA
Emergency Contact (other than parents): _____ Phone: _____

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: _____



FAMILY HISTORY SHEET

Family Last Name: _____

Each Child's First Name in Family: _____

Other Health 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: _____

