

Oakbrook Pediatrics
Patient Information Update Form

Today's Date: _____

CHILD'S NAME: _____ Birth date ___/___/___ Sex: ___ M ___ F
(First, Middle, Last)

Address: _____

City, State, Zip: _____ Race: _____ Email: _____

Insurance Co _____ ID# _____

Policy Holder name & SSN _____

MOTHER'S NAME _____	Birth Date ___/___/___	
Address _____	Home Phone # _____	
Social Security # _____	Marital Status ___	Occupation _____
Employer _____	Work Phone # _____	
FATHER'S NAME _____		Birth Date ___/___/___
Address _____	Home Phone # _____	
Social Security # _____	Marital Status ___	Occupation _____
Employer _____	Work Phone # _____	
Who is legal guardian? _____		

**I authorize Oakbrook Pediatrics to leave a voice message at any phone number I provide.

Exceptions: _____

Have any of your child's brothers and/or sisters ever been seen by our practice? ___Y ___N

If yes, which brothers or sisters? _____

If your child (or children) has not been seen before, who may we thank for referring you to our office? _____

Name of child's previous doctor? _____

Name of parent's family doctor? _____

Name of mother's obstetrician/gynecologist? _____

Person other than parent to contact in case of emergency? _____

Relationship _____ Home Phone # _____

Address _____

I authorize _____ and _____ to bring my child for medical treatment in my absence.

I authorize Oakbrook Pediatrics to release any medical information necessary to process any insurance claim for my son/daughter _____ and request the insurance company to make payments to Oakbrook Pediatrics.

Signature of Parent (over 18yrs) _____ Date _____

Oakbrook Pediatrics
202 Benton's Lodge Road
Summerville, SC 29485
(843) 871-2588

I consent to the treatment of my child, _____ by
Oakbrook Pediatrics and agree to comply with the following office policies:

- **PLEASE DO NOT WEAR PERFUME OR COLOGNE IN OUR OFFICE AS WE HAVE MANY PATIENTS AND STAFF WITH SEVERE ASTHMA AND ALLERGIES.**
- All routine appointments are scheduled in advance with the exception of emergency appointments. These will be worked into the schedule with the understanding that waiting may be a possibility.
- Please make every attempt to arrive on time for your appointment. With the exception of emergencies, anyone arriving later than 15 minutes will be rescheduled.
- We ask that cancellations be made prior to 24 hours of the appointment. If, because of unexpected circumstances, you need to cancel the day of the appointment, we kindly ask that you notify us as soon as possible so that other arrangements can be made.
- An appointment that is neither kept nor cancelled will be considered a NO-SHOW appointment. After three "no-show" appointments, your child may be discharged from the practice.
- I hereby authorize Oakbrook Pediatrics to release or obtain from my insurance company, my child's referring physician or previous physician any medical information which will assist in the course of treatment, including diagnosis and office notes. I authorize insurance payments to be paid directly to Oakbrook Pediatrics, if filed on my behalf.

Signature of parent or legal guardian

Date

OAKBROOK PEDIATRICS, P.A.
Authorization for Release/ Request of PHI

Patient Name _____ Date of Birth _____

I authorize Oakbrook Pediatrics to use/ release information on the above named individual.

___ (REQUEST) use protected health information

send to: Oakbrook Pediatrics, P.A.
202 Benton's Lodge Road
Summerville, SC 29485
PH (843) 871-2588 FAX (843) 871-1664
Preferred: customerservice@oakbrookpeds.com

___ (RELEASE) disclose protected health information to: _____

Information to be used or disclosed: Entire Chart Summary Immunizations

I understand this information may include reference to (check all that apply):

- psychiatric/psychological care (ADD/ADHD)
- sexual assault
- alcohol abuse
- drug abuse
- results of tests for infectious diseases including HIV/AIDS

The purpose of the disclosure is: Treatment

I understand I have the right to cancel /revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing directly to the practice Privacy Contact person, Lisa Hoffmann at 202 Benton's Lodge Road, Summerville, SC 29485. The phone number is (843) 871-2588. Unless otherwise notified this authorization will expire 90 days from this date.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law and that a reasonable fee will be charged as outlined in the Notice of Privacy Practices. I can also refuse to sign this authorization. I also understand my records may be sent by mail or via fax machine.

Signature of Parent/ Legal Representative

Date

Printed Name of Parent/ Legal Representative

Relationship to Patient

Oakbrook Pediatrics
202 Benton's Lodge Rd
Summerville, SC 29485
(843)871-2588

Patient History Information

Date _____

Patient Name _____

Date of Birth _____

Mother's Name _____

Occupation _____

Father's Name _____

Occupation _____

Birth History (complete this section if under 2 years old)

Baby's Due Date _____

Hospital _____

Gestational Age at birth _____

Vaginal or C- section _____

Birth Weight _____

Birth length _____

Breast or bottle feeding _____

Hep B given in Nursery? _____

Check any of the following problems during pregnancy:

Infection _____

diabetes _____

high blood pressure _____

Group B Strep positive _____

bleeding _____

alcohol/drug use _____

Early labor _____

smoking _____

other _____

Did the baby have any of the following problems after delivery?

Infection _____

antibiotics _____

jaundice _____ (level?) _____

Breathing difficulty _____

feeding difficulty _____

low blood sugar _____

Failed hearing screen _____

seizures _____

other _____

Patient's Past Medical History (complete remaining questions for all ages)

Where has your child gone for check-ups before now? _____

Preferred Pharmacy _____ Are Immunizations up to date? _____

Past Hospitalizations/Surgeries _____

Medications _____

Allergies _____

Oakbrook Pediatrics
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-continued---

Has your child had problems with any of the following?

Eyes_____ ears_____ teeth_____ skin rash_____

Wheezing_____ chronic cough_____ chronic runny nose_____

Anemia_____ urination_____ constipation_____

Diarrhea_____ seizures_____ behavior/development_____

Family /Social History

Who lives in the home? _____

Are parents: single_____ married_____ divorced_____ living together_____

Sibling Name_____ DOB_____

Sibling name_____ DOB_____

Sibling name_____ DOB_____

Please list any chronic medical conditions for patient's parents/siblings:

Father: Healthy? Yes/no _____

Mother: Healthy? Yes/no _____

Siblings: Healthy? Yes/no _____

Sibling: Healthy? Yes/no _____

Childcare arrangements_____

Any smokers in the home? _____