R. BLAKE SAYRE, MD., F.A.B.P.
850-437-0035 – 850-429-0005 fax

Patient Information

Patient's Name:_________________________________ Nickname:_______________________________

Date of Birth:____________ Social Security #:____

Address:____ City:______________________________

State:_______ Zip:_____________Telephone:_________________________Sex:_____________________

Emergency Contact Name, Phone #, and Relationship:

____

Mom's Information:

Name:_______________________ Nickname:_________________________DOB:____________

Social Security #:____________________Email:_________________Cell:___________________

Address:___________________________ City:_________________State:_______Zip:_____________

Home #:_____________________Employer:____________________Business#____________________

Dad's Information:

Name:_______________________ Nickname:_________________________DOB:____________

Social Security #:____________________Email:_________________Cell:___________________

Address:___________________________ City:_________________State:_______Zip:_____________

Home #:_____________________Employer:____________________Business#____________________

Insurance Information

Primary Insurance:____Policy #:_____________________

Policy Holder:______________________SS#:___________________DOB:__________________

Secondary Insurance:__________________________________Policy #:______________________

Policy Holder:______________________SS#:___________________DOB:__________________

Other Children

Names & Date of Birth: ____

____

Referred By:

____

Signature:______________________________ Print:__________________________Date:____________________

East Hill Medical Group
-Pediatric Initial History

If possible, attach a copy of your child's immunization record and return with this form at your appointment.

Child's Name		Date of Birth	Age
Address		Form Completed By	Date Completed
Home Phone	Cell Phone		Work Phone

Household – please list all those living in the child's home

Name	Relationship to child	Age	Occupation	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live:

____

____

If parents are not living together or if child does not live with parents, what is the child's custody status?

____

Birth History

Birth weight_______ lbs.________ oz.

Was the baby born at term?____Early?___Late?___

If early, how many weeks gestation?__________

Did mother have any illness or problem with her pregnancy?

Yes / No Explain________________________

____

During pregnancy did mother:

Smoke? Yes / No Drink? Yes / No

Use drugs or medications? Yes / No What? And When:

____

Was the delivery Vaginal? / Cesarean?

If cesarean, why?________________________________

____

Did baby have any problems right after birth? Yes / No

Explain____

____

Was initial feeding Breast? / Bottle?

Did baby go home with mother from the hospital?

Yes / No Explain_______________________________

Date of adoption (if applicable)_____________________

General (if applicable)

Do you consider your child to be in good health? Yes / No Explain____________________________

Does your child have any serious illness or medical condition? Yes / No Explain____________________________

Has your child had serious injuries or accidents? Yes / No Explain____________________________

Has your child had any surgery? Yes / No Explain____________________________

Has your child been hospitalized? Yes / No Explain____________________________

Is your child allergic to any medicine or drugs? Yes / No Explain____________________________

Does our child take any medications on a regular basis? Yes / No Explain____________________________

Development (if applicable)

Name of school (or daycare) and grade in school____

How is his/her behavior in school?____

Has he/she repeated a grade in school?____

How is he/she doing in academic subjects?____

Is he/she in special or resource classes?____

Are you concerned about your child's physical development? Yes / No Explain_________________________

Are you concerned about your child's mental or emotional development? Yes / No Explain_________________________

Are you concerned about your child's attention span? Yes / No Explain_________________________

Family History – have any family members had the following: Unknown____

Deafness	Yes / No	Who______________	Comments_______________________
Allergies (food or environmental)	Yes / No	Who______________	Comments_______________________
Asthma	Yes / No	Who______________	Comments_______________________
Tuberculosis	Yes / No	Who______________	Comments_______________________
Heart disease or sudden death (before 50 years old)	Yes / No	Who______________	Comments_______________________
High blood pressure (before 50 years old)	Yes / No	Who______________	Comments_______________________
High cholesterol	Yes / No	Who______________	Comments_______________________
Anemia/Bleeding disorder	Yes / No	Who______________	Comments_______________________
Liver/Kidney disease	Yes / No	Who______________	Comments_______________________
Diabetes (before 50 years old)	Yes / No	Who______________	Comments_______________________
Epilepsy or convulsions	Yes / No	Who______________	Comments_______________________
Alcohol/Drug abuse	Yes / No	Who______________	Comments_______________________
Mental illness/depression	Yes / No	Who______________	Comments_______________________
Mental retardation	Yes / No	Who______________	Comments_______________________
Immune problems, HIV or AIDS	Yes / No	Who______________	Comments_______________________
Cancer	Yes / No	Who______________	Comments_______________________
Gastrointestinal problems	Yes / No	Who______________	Comments_______________________

Past History – (if applicable) – Does your child have or has he/she ever had:

Chickenpox	Yes / No	When____
Frequent ear infections/hearing loss	Yes / No	Explain____
Allergies (food or environmental)	Yes / No	Explain____
Problems with eyes or vision	Yes / No	Explain____
Asthma, bronchitis, bronchiolitis, pneumonia	Yes / No	Explain____
Any heart problem or heart murmur	Yes / No	Explain____
Anemia or bleeding problem	Yes / No	Explain____
Frequent abdominal pain/constipation	Yes / No	Explain____
Bladder or kidney infection	Yes / No	Explain____
Bed-wetting (after 5 years old)	Yes / No	Explain____
(Girls) Has she started her menstrual period	Yes / No	When and list any problems____________________________
Any chronic or recurrent skin problem	Yes / No	Explain____
Frequent headaches	Yes / No	Explain____
Convulsions or other neurological problems	Yes / No	Explain____
Diabetes	Yes / No	Explain____
Thyroid or other endocrine problems	Yes / No	Explain____
Alcohol/Drug use	Yes / No	Explain____
Any other significant problems	Yes / No	Explain____

Household Environment – Please check all that are in the household where the child resides:

____Smokers	____Smoke detectors	Pets________________
____Guns/Firearms	____Carbon monoxide detectors	type

R. BLAKE SAYRE, MD., F.A.B.P.
850-437-0035 – 850-429-0005 fax

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(East Hill Medical Group reserves the right to modify the privacy practices outlined in the notice at any time.)

I have received a copy of the Notice or Privacy Practices from East Hill Medical Group, and have read and understand the practices protecting my private healthcare information.

____
Name of Patient *(Please Print)*

____
Signature of Patient/Representative

____
Relationship of Representative to Patient

____
Date

99 South Alvaniz Street
Pensacola, Florida 32503

99B South Alcaniz Street- Pensacola, FL 32502
850-437-0035-office 850-429-0005-fax

MEDICAL RECORD RLEASE AUTHORIZATION

Name of Patient (Please Print): ____

Date of Birth: ________________

I hereby authorize the below listed facility, provider or entity to release my medical records to East Hill Medical Group.

Name ____

Address ____

City ______________________________________ State _____ Zip____________

Fax ____

Medical Information Requested:

______ All Records
______ Specific Records from____________to____________
______ Immunizations & Physical Examinations
______ Radiology Films (X-Ray, Mammography, Ultrasound, CT, MRI, etc.)
______ Laboratory Tests

____ ____________________

Signature of Patient/ Responsible Party **Date**

This release authorizes the disclosure of records for one year from this date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, had already done so in reliance on the consent.

____ ____________________

Signature of Patient/ Responsible Party **Date**

R. BLAKE SAYRE, MD., F.A.B.P.
850-437-0035 – 850-429-0005 fax

This form grants authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

Patient Name:____Date of Birth:__________________________

Patient Name:____Date of Birth:__________________________

Patient Name:____Date of Birth:__________________________

Patient Name:____Date of Birth:__________________________

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby grant my authorization and consent for _______________________________ (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment and account balance may be released to the natural mother, natural father, stepmother/stepfather, Designated Adult above, referring physicians, other physicians involved in the care of my child and my insurance company/companies.

Signed this ____________day of____, 20___________.

Parent/Legal Guardian Printed Name:____

Parent/Legal Guardian Signature:____

Witness Signature:____________________________________Printed Name:________________________________

FOR OFFICE USE ONLY

Name of Designated Adult:____

Driver's License #:____Expiration date:_______________________

Verified by Employee Name:____

Employee Signature:____Date:_______________________________