CUMBERLAND FAMILY CARE, PC
Patient Information/Consent for Treatment, Payment, and Daily Operations (please print)

Name_____Date_____
Last First Middle

Address_____ City _____ Zip_____

Date of Birth _____ Age _____ SS #_____

Home Phone:_____ Cell Phone:_____

Pharmacy(be specific) _____

Please Circle One for 1-4 below:

1. Race: (White) (Black) (Hispanic) (Other)_____
2. Is English You Primary Language: **(**Yes) or (No)_____
3. Sex: (Male) (Female)
4. Marital Status: (Single) (Married) (Divorced) (Widowed) (Other)_____

E-mail address: _____

Insurance Plan Information
Please present card at reception
Person responsible for the bill if other than information provided above:

Name_____Relationship_____

Address_____Phone_____

Emergency Contact Information

Name_____ Relationship to patient_____

Phone:_____ Cell _____ Work _____

Authorizations

I understand that I am financially responsible for services rendered by the physician and his staff regardless of insurance, including reasonable attorney's fees and costs of collection in the event of default. I authorize my insurance company to pay benefits directly to the physician. **If applicable: I give consent** for the above patient, who is either under the age of 18 or requires a legal custodian, to receive any treatment that is deemed necessary by Cumberland Family Care, PC. **I understand all of the above** and hereby state that the information is correct to the best of my knowledge. These authorizations apply to all occasions until revoked. My signature indicates that I have read the above and grant to request of authorizations. I give my consent for disclosure of my protected health information for purposes of treatment, payment, daily operations and other disclosures as specifically listed on the Notice of Privacy Practices posted in the lobby of Cumberland Family Care, PC.

Signature_____ **Date**_____

Personal History for Children

Name:_____**Date:**_____

Prenatal Problems: List any problems that occurred while this child's mother was pregnant:

_____

_____

_____

Problems at Birth: List any problems that occurred with this child at birth/shortly afterward:

_____

_____

_____

Birth Weight**:** ___lbs ___oz Doctor Delivering Child:_____ Hospital: _____

Childhood Illnesses (circle): Measles, Mumps, Chicken Pox, Rubella (German Measles), RSV, Croup

Major Illnesses: Check any major diseases this child has/has had:

	Pneumonia		Anemia		Colitis		Hives
	Influenza		Jaundice		Bowel Disease		Eczema
	Rheumatic Fever		Bladder Disease		Food Poisoning		Frequent Infection
	Heart Trouble		Epilepsy		Drug Poisoning		Frequent Boils
	Arthritis		Migraine Headaches		Other Poisoning		Behavior Problems
	Polio		Tuberculosis		Hay Fever		Nephritis
	Meningitis		Diabetes		Asthma		Mumps
	Ear Infections -		How Many?		Measles		

Other Illness: Indicate all other illnesses this child has had.

_____

_____

Injuries: Has this child had any:

Broken/cracked bones (five bone and date):_____

Severe sprains/dislocations (give joint and date):_____

Concussion, head injury or loss/been unconscious:_____

Surgeries: List all operations/surgeries (tonsils, appendix) and this dates:

_____

_____

Hospitalizations: Has this child ever been hospitalized for any illness? Give date and details:

_____

_____

Mental Health: Has this child ever:

Been hospitalized for mental illness? _____

Seen a psychiatrist/counselor? _____

Been a ward of the state or in foster care?_____

Previous Family Doctor(s):_____

Consultants/Specialists: List any other doctors who provide medical care for child:_____

_____

Dentist:_____

Social History

Guardian of child:_____

Marital status of parents of child: Married / Divorced / Separated / Never Married

Father:_____ Father's Residence:_____

Mother:_____ Mother's Residence:_____

Adults that child lives with (if other than parents):_____

Caretakers:_____

Occupations of parents/guardians:_____

Names of siblings of child:_____

Other children living in house:_____

Family Religion:_____ Congregation:_____

Family Health Habits

How many smokers live with this child?:_____

Alcoholism in the immediate family?_____ Which family member(s)?_____

Is the family on a low cholesterol diet?_____

Dose this child get regular exercise?_____ What type?_____

What type of water does the family drink? Well / City / Bottled

What type of structure does child live in? Apartment / House / Trailer How old is it?_____

What city/community does child live in?_____

Hobbies/interests?_____

What is child interested in?_____

Pets in home?_____ Pets outside home?_____

Family Medical History

- Adopted (Please fill in with age of onset for each family member)

Family Name (Please Circle Status)	Date of Birth	Heart Attack	Mental Illness	Seizures	Cancer (Specify Type)	Diabetes	High Blood Pressure	Stroke	High Cholesterol	Alcohol/ Drug Abuse	Other (Please Specify)
Mother: Living / Deceased											
Father: Living / Deceased											
Sibling: Living / Deceased											
Sibling: Living / Deceased											
Sibling/Other: Living / Deceased											
Sibling/Other: Living / Deceased											
Other (Please Specify):											
Other (Please Specify):											
Other (Please Specify):											
Other (Please Specify):											

Medications

Medication Allergies:_____

Pharmacy:_____

Medication: Please list medication you currently take regularly (including over the counter meds and supplements.

Name	Dosage (mg)	# Pill Per Dose	# Doses Daily	Reason for Taking Medication