Mooresville PPM, LLC

Outpatient Information

PATIENT INFORMATION	Account #:		Medical Record#:	Date:	
Patient Name:			Referring Doctor:		
Billing Address:			City	State	Zip
Physical Address:			City	State	Zip
(H) Phone:	(C) Phone:		Work Phone:	Other:	
Primary Doctor			Employer/School:		
Social Security #:	Date of Birth:	Age	Martial Status:	Sex:	
Emergency Contact:	Relationship:		(H) Phone:	(C) Phone:	
Responsible Party:	Relationship:		DOB:	SS#:	
Email (responsible party if minor/child)					
Responsible Party Address:					
City:	State	Zip	(H) Phone:	(C) Phone:	
INSURANCE INFORMATION					
Primary Insurance:	Employer:		Secondary Insurance:	Employer:	
Insurance ID #:	Insurance Group #:		Insurance ID #:	Insurance Group #:	
Insured Name:			Insured Name:		
Address:			Address:		
City	State	Zip	City	State	Zip
DOB:	Insured Social Security #:		Insured DOB:	Insured Social Security #:	

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Mooresville PPM, LLC and its affiliates (Mooresville PPM, LLC) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Mooresville PPM, LLC for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Signature of Patient or Authorized Person: _____ ***Date/Time:*** _____

Insured Party or Financial Guarantor (if different from above): _____ ***Date/Time:*** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

❑ Interpreter Accepted _____ ❑ Interpreter Refused

(Name/Number of Person/Services Chosen/Used

REV. 2-11

Patient Name _____ Birth date _____

Form Completed By _____ Chart Number _____

Date _____ Nurse Initials _____

Household

Please list everyone living in the child's home

Name	Relationship to Child	DOB	Health Problems

Birth History

Birth weight_____ APGAR_____/_____ Was the delivery ☐ Vaginal ☐ C-section

If C-section, why?_____

Was the baby born at term?_____ Early?_____ Late?_____

If early, how many weeks gestation?_____ Did the baby have any problems right after birth?

☐ Yes ☐ No Explain_____

Did mother have any problem with her pregnancy?

☐ Yes ☐ No Explain_____

Was initial feeding ☐ Breast ☐ Bottle

During pregnancy, did mother

Did your baby go home with mother from hospital?

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No ☐ Yes ☐ No Explain_____

Use drugs or medications ☐ Yes ☐ No

What_____ When_____

General

Do you consider your child to be in poor health? ☐ Yes ☐ No Explain _____

Does your child have a serious medical condition? ☐ Yes ☐ No Explain _____

Has your child had significant injuries/accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medications? ☐ Yes ☐ No Explain _____

Does your child take any regular medications? ☐ Yes ☐ No Explain _____

Development

When did your child: Sit up _____ mos. Crawl _____ mos. Walk _____ mos. First sentence _____ Toilet trained _____

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

How is your child's behavior in school? _____

Has he/she failed or repeated a grade? _____

What kind of grades does he/she make in academic subjects? _____

Is he/she in a special or resource classes? _____

MOORESVILLE PPM, LLC

Pediatric History Questionnaire

Family History

Have family members (Patient's mother, father, sister, brother, aunt, uncle, grandfather, grandmother) had the following:

Significant allergies	☐ Yes	☐ No	Who/Explain _____
Asthma	☐ Yes	☐ No	Who/Explain _____
Deafness	☐ Yes	☐ No	Who/Explain _____
Tuberculosis	☐ Yes	☐ No	Who/Explain _____
Heart disease (onset before age 50 yrs.)	☐ Yes	☐ No	Who/Explain _____
High blood pressure (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain _____
Stroke (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain _____
Diabetes (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain _____
High cholesterol	☐ Yes	☐ No	Who/Explain _____
Anemia, leukemia, free bleeding	☐ Yes	☐ No	Who/Explain _____
Liver disease	☐ Yes	☐ No	Who/Explain _____
Convulsions or seizures	☐ Yes	☐ No	Who/Explain _____
Migraine	☐ Yes	☐ No	Who/Explain _____
ADHD/learning disability	☐ Yes	☐ No	Who/Explain _____
Mental illness/suicide	☐ Yes	☐ No	Who/Explain _____
Mental retardation	☐ Yes	☐ No	Who/Explain _____
Immune deficiency/HIV/AIDS	☐ Yes	☐ No	Who/Explain _____

Review of Systems

Does your child have, or has he/she ever had:			(if "Yes" please explain)
Chickenpox	☐ Yes	☐ No	Explain _____
Frequent ear infections	☐ Yes	☐ No	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	Explain _____
Allergies	☐ Yes	☐ No	Explain _____
Problem with eyes or vision	☐ Yes	☐ No	Explain _____
Asthma, wheezing, bronchiolitis	☐ Yes	☐ No	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	Explain _____
Blood transfusion	☐ Yes	☐ No	Explain _____
Severe abdominal pain	☐ Yes	☐ No	Explain _____
Recurrent vomiting	☐ Yes	☐ No	Explain _____
Chronic diarrhea	☐ Yes	☐ No	Explain _____
Constipation requiring office visits	☐ Yes	☐ No	Explain _____
Bladder, kidney or urinary tract infections	☐ Yes	☐ No	Explain _____
Bed-wetting after 5 years old	☐ Yes	☐ No	Explain _____
(For girls) Has she started her menstrual period	☐ Yes	☐ No	Explain _____
(For girls) Are there any problems with periods	☐ Yes	☐ No	Explain _____
Any chronic or recurring skin problems	☐ Yes	☐ No	Explain _____
Severe headache	☐ Yes	☐ No	Explain _____
Convulsions, seizures, or concussions	☐ Yes	☐ No	Explain _____
Thyroid or gland problem	☐ Yes	☐ No	Explain _____

☐ Updated _____	Initials _____	☐ Updated _____	Initials _____
☐ Updated _____	Initials _____	☐ Updated _____	Initials _____
☐ Updated _____	Initials _____	☐ Updated _____	Initials _____