MANSOOR PEDIATRICS PROGRESS NOTES

NAME: _____ MALE / FEMALE DOB: _____

DATE	

MANSOOR PEDIATRICS PATIENT INFORMATION

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME_____M.I. _____
DOB: _____ SOCIAL SECURITY #: _____ - _____ - _____
GENDER: MALE FEMALE

PARENT / GUARDIAN INFORMATION

MOTHER:

LAST NAME: _____ FIRST NAME_____M.I. _____
DOB: _____SOCIAL SECURITY #: _____ - _____ - _____ DRIVERS LICENSE #_____ _____
ADDRESS: _____
CITY: _____STATE: _____ ZIP CODE: _____
PHONE NUMBER(s): HOME: _(_____)_____ CELL _(_____)_____
WORK: _(_____)_____ EMAIL: _____

FATHER:

LAST NAME: _____ FIRST NAME_____M.I. _____
DOB: _____SOCIAL SECURITY #: _____ - _____ - _____ DRIVERS LICENSE #_____ _____
ADDRESS: _____
CITY: _____STATE: _____ ZIP CODE: _____
PHONE NUMBER(s): HOME: _(_____)_____ CELL _(_____)_____
WORK: _(_____)_____ EMAIL: _____

INSURANCE INFORMATION

PLEASE MARK ALL THAT APPLY:
MEDICAID: #_____
SELF PAY: _____

PLEASE PROVIDE PROOF/ COPY OF THE FOLLOWING

INSURANCE / MEDICAID CARD: _____
SOCIAL SECURITY CARD: _____
DRIVERS LICENSE: _____
SHOT RECORD: _____

IF PRIVATE INSURANCE PLEASE COMPLETE THE FOLLOWING

_____
NAME OF POLICY HOLDER

_____ _____
POLICY HOLDERS SOCIAL SECURITY& DATE OF BIRTH

PRIVATE INS: #_____
GROUP # _____

EMERGENCY CONTACT PERSON : _____RELATIONSHIP: _____
PHONE#: (_____)_____

I authorize the release of any medical or other information necessary to process a claim on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from Mansoor/Healthy Steps Pediatrics whether covered by my insurance or not.

_____ _____
Signature Date

MANSOOR PEDIATRICS

****** Please complete the following information if you do not have a copy of your child's shot record with you. If you have the shot record, please give it to the receptionist to copy and place in the chart.**

I, _____,
Parent/Guardian of _____
____Refuse Immunization offered at this time
____Refuse to start the immunization series
____Refuse _____ immunization
____Do not have my child's shot record at this time

I make this refusal because:
____Previous reaction to immunization
____Child is up to date on Immunizations
____ Other (Please explain):

_____
I have been counseled by a staff member on the need for the current immunizations for school attendance and the health risk posed to my child through inadequate immunization status. I understand these facts as they are presented to me.

_____
Parent/Guardian Date

_____
Witness

NAME: _____ DATE OF BIRTH: _____

BIRTH AND DEVELOPMENT HISTORY

Problems with pregnancy? _____
What was child gestational age? _____
Birth weight: _____ Birth length: _____
Hospital where born _____ Talk _____ Other _____
Type of delivery and problems _____ Toilet Train _____

At what age did child:
Smile _____ Roll Over _____
Sit alone _____ Walk _____

PAST MEDICAL HISTORY

Has your child:

Had a serious illness? ☐ Yes ☐ No
Ever been hospitalized? ☐ Yes ☐ No
Ever had surgery? ☐ Yes ☐ No
Ever had a major injury? ☐ Yes ☐ No
Is your child taking any medications? ☐ Yes ☐ No
Does your child have any allergies? ☐ Yes ☐ No

Explain any "Yes" answers:_____
_____

Has your child had:
☐ Measles ☐ Chicken Pox ☐ Mumps ☐ Meningitis ☐ Other_____

CURRENT PROBLEMS

☐ Asthma
☐ Bed Wetting
☐ Frequent Tonsillitis
☐ Ear Infections
☐ Hearing Problems
☐ Diabetes
☐ Bowel Problems
☐ Drug Use
☐ Bladder / Kidney Problems
☐ Sickle Cell Disease/Trait
☐ Other _____

☐ Anemia
☐ Vision Difficulty
☐ Heart Problems
☐ Breathing Problems
☐ Eye Problems
☐ Seizures
☐ Tobacco Use
☐ Alcohol Use

FAMILY MEDICAL HISTORY

Key: F (father) M (mother) FP (father's parents)
MP (mother's parents) S (siblings) PS (parent's siblings

	F	M	PS	FP	S	MP
High Blood Pressure						
Allergies/Asthma						
Stroke						
Hepatitis						
Heart Problems						
Anemia						
Cancer						
Diabetes						
TB/Lung Problems						
Kidney Disease						
Genetic Disorders						
Sickle Cell						
Alcohol/Drug Use						
Mental/Nerve disorder						
Other						

Date Obtained or Updated	Signature	Area where changes noted