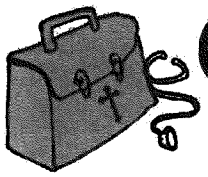

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PLEASE PRINT AND COMPLETE IN FULL

Date:_____

Name:_____ Nickname:_____
Last First M

Sex: Male____Female____ Birthdate:_____Age:_____ Social Security#:_____

If Patient is a minor, Parent / Guardian's Name:_____

Patient's Street Address:_____

City, State, Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Emergency Contact Name and Phone Number:_____

Patient's Marital Status: Married___ Single____ Spouse Name_____

How did you hear about us? Supertalk 99.7_____ Friend/Family_____ Internet_____ Groupon____

Television____ Networking Event____ Other (Please Specify)_____

Reasons for visit (please be specific):_____

_____

_____

How will you pay today? Cash_____Check_____Credit Card_____ HSA/FSA Card _____

I understand payment in full is due at time of service.

I understand that a 24 hour notice is required for appointment cancellations and I will be charged a $49 fee if I fail to make my appointment without canceling at least 24 hours in advance.

Patient (or legal guardian) Signature_____

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PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	M F

Previous Physician	Request for Records Transfer Complete Y N	Date of Last Well Child Exam

Mother's Full Name	Father's Full Name
Step-Mother's Full Name (If Applicable)	**Step-Father's Full Name (If Applicable)**
Custodial Provider's Full Name (If different from above)	**Relationship to Patient**

Birth History

Birth Weight _____ Preg#_____ Mom's age_____ Was the birth ☐ Vaginal ? ☐ Cesarean? ☐ Early? ☐ Late?

If birth was early, how many weeks early? _____ If Cesarean, why? _____

Did mother have any illnesses/problems with her pregnancy? ☐ Yes ☐ No Explain _____

Did baby have any problems right after birth? ☐ Yes ☐ No Explain_____

Before mother knew she was pregnant or at any time during her pregnancy did she:

☐ Smoke Cigarettes (amount)_____ ☐ Drink Alcohol (amount) _____

☐ Use "street" drugs (type)_____ ☐ Use Prescription Drugs (type)_____

Was initial feeding ☐ Breast Milk? ☐ Formula?

Current and Past History

Is your child currently on any medication?	☐ Y	☐ N	Explain_____
Does your child have any serious or chronic illnesses?	☐ Y	☐ N	Explain_____
Has your child had serious injuries or accidents?	☐ Y	☐ N	Explain_____
Has your child had any surgeries?	☐ Y	☐ N	Explain_____
Has your child ever been hospitalized?	☐ Y	☐ N	Explain_____
Is your child allergic to any medications?	☐ Y	☐ N	Explain_____
Has your child ever reacted to immunizations?	☐ Y	☐ N	Explain_____

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	☐ Y	☐ N	Explain_____
Nasal allergies or eczema	☐ Y	☐ N	Explain_____
Frequent ear infections or sore throat	☐ Y	☐ N	Explain_____
Problems with ears or hearing	☐ Y	☐ N	Explain_____
Problems with eyes, vision or teeth	☐ Y	☐ N	Explain_____
Frequent headaches or other neurologic problems	☐ Y	☐ N	Explain_____
Frequent abdominal pain	☐ Y	☐ N	Explain_____
Constipation requiring doctor visits	☐ Y	☐ N	Explain_____
Bladder/kidney problems or bedwetting	☐ Y	☐ N	Explain_____
Any heart problems/murmur	☐ Y	☐ N	Explain_____
Anemia or bleeding problem	☐ Y	☐ N	Explain_____
Thyroid or other gland problem	☐ Y	☐ N	Explain_____
Diabetes	☐ Y	☐ N	Explain_____
ADD/ADHD	☐ Y	☐ N	Explain_____
Mental Health Issues	☐ Y	☐ N	Explain_____
Use of drugs or alcohol	☐ Y	☐ N	Explain_____

Household Information

Please List All Those Living in the Child's Home		
Name	**Relationship to Child**	**DOB**

Are there siblings not listed above? If so, please list their full names and ages and where they live. _____

_____

_____

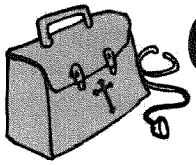
Child Care:_____

Smokers in household? □ Y □ N

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	□ Y	□ N	Who_____	Comments_____
Allergies	□ Y	□ N	Who_____	Comments_____
Asthma	□ Y	□ N	Who_____	Comments_____
Birth Defects	□ Y	□ N	Who_____	Comments_____
Blood Disorders	□ Y	□ N	Who_____	Comments_____
Bone Disorders	□ Y	□ N	Who_____	Comments_____
Cancer	□ Y	□ N	Who_____	Comments_____
Diabetes	□ Y	□ N	Who_____	Comments_____
Endocrine Disease	□ Y	□ N	Who_____	Comments_____
Ear/Nose/Throat Disorders	□ Y	□ N	Who_____	Comments_____
Eye Disorders	□ Y	□ N	Who_____	Comments_____
Gastrointestinal Disorders	□ Y	□ N	Who_____	Comments_____
Heart Disease	□ Y	□ N	Who_____	Comments_____
High Blood Pressure	□ Y	□ N	Who_____	Comments_____
High Cholesterol	□ Y	□ N	Who_____	Comments_____
Immune Disorders	□ Y	□ N	Who_____	Comments_____
Joint Problems	□ Y	□ N	Who_____	Comments_____
Kidney Disease	□ Y	□ N	Who_____	Comments_____
Liver Disease	□ Y	□ N	Who_____	Comments_____
Lung Disease	□ Y	□ N	Who_____	Comments_____
Migraine Headaches	□ Y	□ N	Who_____	Comments_____
Metabolic Disorders	□ Y	□ N	Who_____	Comments_____
Obesity	□ Y	□ N	Who_____	Comments_____
Seizure Disorders	□ Y	□ N	Who_____	Comments_____
Skin Disorders	□ Y	□ N	Who_____	Comments_____
Stroke History	□ Y	□ N	Who_____	Comments_____
Thyroid Disorders	□ Y	□ N	Who_____	Comments_____
Mental Health History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____



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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Dr. Edward C. Leichner, D.O.
Robert M. Tomsett Jr., PA-C
Krystal H. Lynch, WHNP-BC
Retha Thomas, FNP-BC

I understand I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare provider's who may be involved in that treatment directly and indirectly.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

If Guardian; Relationship to Patient: _____

Patient / Guardian Signature: _____

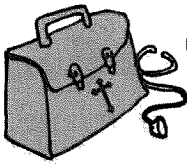
Today's Date: _____

.....

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____



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RELEASE AND ASSIGNMENT

I understand that in certain situations payment for services may not occur at the conclusion of my visit or in other cases, such as pathology services, GracePointe Healthcare may have to bill me for additional costs after my visit and that I am responsible for payment of all services rendered. I will pay all collection fees, court costs, attorney fees, and any other expenses required to reimburse GracePointe Healthcare, for services rendered.

Patient / Guardian Signature: _____ Date: _____

.....

I understand that GracePointe Healthcare uses automated appointment reminders that send emails, phone calls, and/or texts to remind me of my scheduled appointment. I consent to receiving these reminders and understand I can opt out at any time.

Patient / Guardian Signature: _____ Date: _____

.....

I understand that the office staff of GracePointe Healthcare may need to reach me via telephone. In the event I am unavailable, I authorize the office staff of GracePointe Healthcare to leave a message on my voicemail requesting a return call.

Patient / Guardian Signature: _____ Date: _____

.....

The office staff of GracePointe Healthcare may discuss my health care with the following individuals:

_____ _____

Name Phone Number / Relationship

_____ _____

Name Phone Number / Relationship

_____ _____

Name_____ Phone Number / Relationship _____

Patient / Guardian Signature:_____ Date: _____