West Ashley: 1871 Savage Road Charleston, S.C. 29407
Goose Creek: 105 Springhall Drive Goose Creek, S.C. 29445
Hanahan/ North Charleston: 1818 Remount Road Hanahan, SC 29410
Phone: (843) 766-6308 Fax:866-533-4473

Section 1: Patient Information

First Name:	Middle Name:	Last Name:	Preferred Name:
Date of Birth:	Age:	Sex: □ Male □ Female	SSN:
Street Address:		City:	State: / Zip Code:
County:		School:	School Fax#: (used for school forms)
Sibling Names and Ages:			
Emergency Contact:		Emergency Contact Relationship to Patient:	Emergency Contact Phone Number:
Primary Language:		Ethnicity: □ Hispanic Origin □ Not Hispanic Origin	**Employment Status**: □ Full Time □ Part time **Student Status**: □ Full Time □ Part time

Race:
□ Caucasian □ Afr. American □ Asian □ Hispanic □ Native Hawaiian/Pacific Islander □ Middle Eastern □ North African □ Other: _____

Religion:
□Christianity □Catholicism □Hinduism □Mormonism □Judaism □Islam □Buddhism □Protestantism □ :Other_____ □Choose not to disclose

Primary Care Physician:

West Ashley: □ J. Traynham. MD □T. Vasko. MD □P. McGaha. MD □T. Tyner. MD □M. Vasko. PA □A. Clark, CPNP □ Tim Buttram, PA-C

Goose Creek: □S. Stadalsky. MD □P. Hamilton. MD □J. Hyde. CPNP □ Tim Buttram, PA-C

Hanahan: □ W. Martin. MD □ K. Overcash. PA-C □ Tim Buttram, PA-C

How did you hear about us?

Section 2: Insurance & Pharmacy Information

Primary Insurance Name:	Secondary Insurance Name:	Insurance Policy Holder Name & DOB:
Preferred Pharmacy:	Pharmacy Address:	Pharmacy Phone Number:

Section 3: Parent/Legal Guardian Information

Parent/Legal Guardian #1:

First Name:	Middle Name:	Last Name:	**SSN:**
Date of Birth:	Age:	Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	E-mail Address:
Street Address: (if different from patient)		City: State:	Zip Code:

Parent/Legal Guardian #2:

First Name:	Middle Name:	Last Name:	SSN:
Date of Birth:	Age:	Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	E-mail Address:
Street Address: (if different from patient)	City:	State:	Zip Code:

Information Sharing and Access

I authorize Neighbors Pediatrics to send me important updates via SMS/Text (message and data rates may apply) to the number provided. We will only contact you regarding appointment reminders, medical services, billing, or matters related to medical care. Please note, only one phone number can be listed for text reminders.

☐ Yes ☐ No Phone Number: _____

I authorize Neighbors Pediatrics to leave a voice mail regarding:

☐ All information including appointments, general info, updates, billing, etc. ☐ Appointment information only

If you would like someone other than the patient's parents/legal guardians to receive or access information about their medical care, please select the information that you authorize us to give out for this patient below. Additionally, please list who has permission to receive or access this information.

Parents do not need to be listed in this section unless the child is 16 years or older. South Carolina law states that at age 16, a patient has the right to choose who has access to medical information.

Type of Information:

☐ Results of Lab Tests/X-rays ☐ Appointment Information ☐ Scheduling Appointments ☐ Medical Information ☐ Billing Information ☐ Payments

Authorized Parties to Receive or Access Information:

Name:	Relationship to Patient	Phone number	Authorized to Bring to an Appt? ☐ Yes ☐ No
Name:	Relationship to Patient	Phone number	Authorized to Bring to an Appt? ☐ Yes ☐ No
Name:	Relationship to Patient	Phone number	Authorized to Bring to an Appt? ☐ Yes ☐ No
Name:	Relationship to Patient	Phone number	Authorized to Bring to an Appt? ☐ Yes ☐ No

An Authorization to Release Information Form must be completed for all releases and disclosures not listed in the section below. A Request for Restrictions must be completed in writing to request restrictions for the use of your information. Any Restrictions involving guardianship must have court documentation with specific instructions for medical care.

Ambulatory Consent to Treatment

I, _____(as patient, parent, guardian, spouse, guarantor, or other responsible party), consent to and authorize medical treatment and diagnostic procedures which may be ordered and/or provided by my doctor and performed at Neighbors Pediatrics/Tribe 513 ambulatory locations.

I understand that this consent for medical treatment, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice.

HIPAA Notice of Privacy Practices Consent

Tribe513 & Neighbors Pediatrics, Notice of Privacy Practices can be found by following the QR code.

I certify that I have reviewed and/or received a copy upon request of the Tribe513, Neighbors Pediatrics "Notice of Privacy Practices". I understand that uses and disclosures of my personal health information are described in the Notice of Privacy Practices received. Possible disclosures include, but are not limited to, disclosure to another health care provider or Health Information Exchanges (HIE) for treatment, process of payment, or Tribe513 & Neighbors Pediatrics operations. See attached Notice of Privacy Practices for additional possible disclosures and instructions on how to limit my participation in HIE or to whom my health information is disclosed.

I understand that this consent for medical treatment, including all routine testing, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice.

I understand that the authorization for release of information, which is a separate form I will complete, will be valid for one year from the date of acceptance and can only be modified or revoked upon written notice.

I certify that I have read or have had read to me this consent and agree to its terms. I also certify that I am the patient, or am duly authorized by the patient, or am duly appointed to sign this agreement. I accept and understand its terms.

To the best of my knowledge, the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informated of changes to any of my contact information.

Print Patient's Name	Patient's Signature (if 16 years or older)	Phone Number:
Print Legal Guardian Name:	Legal Guardian Signature:	Today's Date:

Only the biological parent, legal guardian, or patient can consent to medical treatment and sign this documentation.

Responsible Party			
Patient Last Name	Patient First Name:	Patient Middle Initial:	Patient Date of Birth:

The Responsible Party is the person who is FINANCIALLY responsible for any balance on the patient's account not covered by insurance. This person will receive all account statements to their address. You CANNOT delegate another person to be the responsible party. If you are 18 or older, you are your own responsible party.

The following section can only be completed and signed by the Responsible Party.

Waiver of Liability: I understand that the treatment/service from the providers and physicians at Tribe513 and Neighbors Pediatrics for the patient listed above may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due.

Payment Policy: Tribe513 and Neighbors Pediatrics are committed to providing the best treatment for our patients. Our pricing structures are representative of the usual and customary charges for our area.

Responsible Party Acknowledgement: I understand that I am the responsible party for the patient listed above and agree to the terms of the Waiver of Liability and Payment Policy. I have been given a copy for review and I am aware of the availability of these documents in the office at a Tribe513 entity and online at www.tribe513.org. By signing, I agree to adhere to the requirements outlined in the policies provided for the above patient at Tribe513 entities, including Neighbors Pediatrics.

Responsible Party Full Name:	Relationship to Patient:	Responsible Party Date of Birth:	
Street Address:	City:	State:	Zip Code:
Phone Number:	E-mail:		
Responsible Party Signature:	Date:		

Guardianship Statement:

Only the patient, biological parent, or legal guardian may provide or change demographic information. If you are not the biological parent(s), please provide a copy of the required legal documentation describing guardianship.

Neighbors Pediatrics
Vaccine Eligibility and Screening Record

Print Patient's Name	Date of Birth	Today's Date:

Thank you for selecting Neighbors Pediatrics as your child's primary care provider. One of our primary goals is to build a relationship of mutual responsibility and trust with you by providing complete and quality medical care. One of the ways we do this is by screening your vaccine eligibility. We ask that you inform us upon arrival for your appointment of any changes to your health insurance plan; in particular if your child is receiving vaccinations. To qualify for programs please see the options below.

To ensure that there are no additional costs for you:

- If you choose not to vaccinate at today's visit, please note you must inform medical assistant at beginning of visit to ensure vaccines are not charged to your account.
- ONE of the following selections must be made prior to vaccine administration.

Option A: VFC Vaccines -Vaccines for Children program FOR SELF PAY OR MEDICAID PATIENTS <18 years

South Carolina's VFC program has been established for those children 0 through 18 years of age who are enrolled in Medicaid, have No Health Insurance (self-pay) or American Indian or Alaska Native. If you have no health coverage your child qualifies for VFC, and your vaccinations are provided at a minimal cost to you. You are required to pay a maximum of $49.40 per visit for the shots. (This is in addition to your co-pay or coinsurance and is due upon checkout.)

This child qualifies for VFC vaccines because he / she (check only one)

- ☐ Is enrolled in Medicaid and under the age of 19
- ☐ Does not have health insurance, (Self pay) – administration fee not to exceed $49.40
- ☐ Is American Indian or Alaskan Native

I have read and understand the above information and request that my child receive VFC vaccines.

Parent/Guardian Signature: _____ Date: _____

Option B: SC State program – FOR UNDERINSURED/VACCINES NOT COVERED BY INSURANCE PLAN SC

State vaccine program has been established for the insured hardships and vaccine caps. Insured hardship is defined as "health insurance deductible greater than $250 per child or $500 per family. Eligibility for state vaccine only if the deductible has not been met and the family cannot afford to pay for the vaccine. Vaccine Caps is defined as "insured but coverage capped at certain amount and cap has been exceeded." The Human Papillomavirus Vaccine (HPV) is excluded for the SC State vaccine program. I have read and understand the above information and request that my child receive SC State funded vaccines. Name of insurance company:

Parent/Guardian Signature: _____ Date: _____

Option C: Private Vaccines- FOR INSURANCES THAT COVER VACCINES

Private vaccinations are given to children whose insurance covers vaccinations at 100% coverage. These vaccinations are purchased from the manufacturers and billed to your insurance company for reimbursement. By signing below, you are stating your insurance carrier covers your vaccinations at 100% and are requesting we bill your insurance carrier for reimbursement. If the vaccinations are not covered, you will be responsible for the cost of the vaccination and administration fees. Our Private Vaccines are billed separately through Vaxcare. Please be aware that they are affiliated with Neighbors Pediatrics but will be billed separately. I have read and understand the above information and request that my child receive Private vaccines. Name of insurance company: I understand that if my insurance does not pay for these vaccines that I am responsible for the balance of any unpaid charges.

Parent/Guardian Signature: _____ Date: _____

Neighbors Pediatrics
Split Visit Policy: Wellness Exams

Thank you for choosing Neighbors Pediatrics for all your child's health needs. We practice comprehensive medicine which includes a Preventative Annual Exam. We will bill the insurance company you have provided for the preventative service.

If you have any other medical concerns you would like to address during this visit, including chronic medical conditions requiring follow-up, the extra services may not be considered part of your preventative service insurance benefits. Examples being ADHD (attention deficit hyperactivity disorder) medication follow up, any symptoms of illness or other services that are not deemed preventative by your insurance company. You may be responsible for any non-preventative services rendered today that are not covered by your insurance carrier. It is important for you to understand your individual insurance benefit coverage because each plan may have different coverages.

By signing this document, you agree to the guidelines in our policies.

Print Patient's Name	Patient's Signature (if 16 years or older)	Phone Number:
Print Legal Guardian Name:	Legal Guardian Signature:	Today's Date:

Neighbors Pediatrics
Patient Portal

Thank you for your interest in our Patient Portal.

This web-based program will provide another opportunity for your Provider to communicate your healthcare information. By signing up for the program, you will receive an email in the account you have provided to us. This email will contain your username and a one-time password. You will be asked to confirm your identity by verifying information we have on record for you. You will be provided with consent to proceed with enrollment and a disclosure notice for privacy purposes. You will be requested to change the one-time password to a password that you select.

When you receive emails from our office, they will not contain private information but will advise you that you have a message from your provider. You will need to log into the patient portal to view the sent information. Please understand that the information within the patient portal will contain your private health information. We are not responsible for the security of the email account you choose to use for the patient portal or your passwords to the program. If you share the provided email account with others, you may want to consider providing an alternative email account to ensure your private healthcare information is unable to be accessed by other account users.

If you would like to continue with enrollment in the Patient Portal, please complete the area below.

By completing this form, I acknowledge that this enrollment is elective, that the account provided will contain access information to a program that will contain my private health information, and that I am responsible for the privacy of this account and any associated access.

Print Patient's Name	Patient's Date of Birth:	Today's Date:
Parent/Legal Guardian Signature (or patient if >18):	E-mail Address for Account:	

DECLINE: ☐ If you would like to Decline, please still fill out patient information and sign.

*Please note that only one email can be associated with a patient portal account. For more than one person wanting access to a patient's account please know that the User ID and Password would need to be shared.

Neighbors Pediatrics
Payment Policy

Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. The following information answers frequently asked questions regarding patient and insurance responsibility for services rendered during your visit. Feel free to ask us any questions and sign in the space provided. A copy will be provided to you upon request.

PAYMENTS ARE DUE AT THE TIME OF SERVICE.

SELF-PAY (NO INSURANCE): For self-pay patients, you will be required to pay in full at the time of service to receive the discount. Otherwise, sick patients will be expected to pay a minimum of $100. All remaining balances will be billed to you. If you need payment assistance, please ask the representative for further information.

INSURANCE: We participate with most insurance plans. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and dictates the amount due by the patient. You need to contact your insurance company to verify participation, benefits (including if the insurance covers vaccinations), and copay/deductible. If your insurance company informs us that you are ineligible for benefits, you will be considered self-pay (no insurance), see above, or you can reschedule your visit. It is your responsibility to comply with their requests. You will need to contact them if you disagree with their determination on the payment of your claim. If you fail to provide us with this information in a timely manner, you may be responsible for the balance on your account.

CO-PAYMENTS AND DEDUCTIBLE: All co-payments, deductibles, and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your deductible has not been met, we expect you to pay at least $25.00 at the time of your visit. State employees have preset pricing.

METHODS OF PAYMENT: We accept Cash, Debit/Credit Cards, HSA Cards. Checks are also accepted for mailed payments. For returned checks your account will be charged $25.00. The check and service fee must be paid in full before your next visit.

PATIENT STATEMENTS: If you have an unpaid balance, you will receive a statement monthly. Balances over 90 Days will be turned over to our internal collection department and/or may be submitted to an outside collection agency with possible dismissal from the practice.

PAYMENT PLANS: We offer convenient, affordable payment plans for our in-house accounts (minimum $25 monthly payment). Please see our business office team for details.

I have read, understand, and will comply with the terms of the Payment Policy.

Print Patient's Name	Patient's Date of Birth:	Today's Date:
Print Parent/Legal Guardian Name:	Parent/Legal Guardian Signature:	

Neighbors Pediatrics
Practice Policies

PLEASE PAY CLOSE ATTENTION TO THE GRACE PERIOD TO AVOID ANY DELAYS IN YOUR CARE

To provide you with high quality health care it is important for you to keep the scheduled appointment with the medical provider. Valuable time has been reserved for you or your family member. By cancelling your appointment as soon as possible, we can help other patients who are waiting to be seen.

It is your responsibility to keep a record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment, please call 24 hours in advance between the hours of 8:00 am and 4:50 pm.

For after-hour cancellations we have an answering service for your convenience to leave a message.

Late Grace Period: A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their appointment, the schedule may not allow us to see you and we may need to reschedule the appointment. Please call us before you are late to see if we will be able to see you or if there is a need to reschedule.

No Show Policy: Patients who cancel appointments with less than 24 hours' notice will be considered a No Show. Every No-Show visit will be recorded in your chart. Multiple No Show appointments within a 1-year period can result in a discontinued relationship between you and your provider. We realize that an emergency may occur, and you may not be able to notify us in a timely manner. Please notify us of emergency within 24 hours after the appointment for reconsideration of No Show.

- After One (1) No Show: You will receive a letter informing you of the No Show with a copy of this policy/agreement. You will be able to continue to receive medical services at Neighbors Pediatrics.
- After Two (2) No Shows: You will receive a second letter reminding you that this is your 2nd No Show. You will still be able to receive medical services at Neighbors Pediatrics.
- After Three (3) No Shows: Your Primary Care Physician is notified of your appointment history. He or she will determine if the relationship between you and your provider will continue. If dismissed, you will receive written notification. We agree to see your child for 30 days after notification for Urgent Care visits only.

Referral Policy: Our referrals department will follow up with the specialist office. If the referral is not fulfilled within 6 months, the referral may be closed. Once the referral is closed, an office visit may be required to receive a new referral.

Office Recording Policy: To ensure your privacy and the privacy of other patients during your visits, photography, videography, and/or other audio recordings are strictly forbidden on the premises, unless express permission is otherwise granted by a Team Member of Neighbors Pediatrics.

Thank you for working with us to ensure that services are provided to all our patients in the best possible way.

I have read and acknowledge the Practice Policies.

Print Patient's Name	Patient's Date of Birth:	Today's Date:
Print Parent/Legal Guardian Name:	Parent/Legal Guardian Signature:	

Neighbors Pediatrics
Patient-Centered Medical Home
Fact Sheet

What is a patient centered medical home?

The Medical Home is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care (AAP policy statement, 2008).

At Neighbors Pediatrics with MUSC Children's Health, we understand the importance of having a consistent medical home. This means that we work together as a team to provide the most comprehensive care for every patient. Our team includes our Neighbors Pediatrics providers, nurses, medical assistants, and staff, as well as other external referred resources and specialists, and the most important member – the patient! We act as a central hub of information and care to ensure that all areas (physical, psychological, emotional, and developmental, etc.) are being addressed and monitored over the long term. This is a proven way to detect any areas of concern as well as build trust and a long-term relationship with the patient as a Neighbors family.

As a Medical Home we will also help find needed information and resources, such as information about:

- Pediatric specialists
- Health conditions/latest treatments
- Home care, equipment, and vendors
- Support and respite services for your family
- Other key local services

We will also:

- Take care of every child when he or she is sick and well and help promote wellness
- Help plan the child's care and/or set goals for care, now and for the future
- Talk with patient and family about any testing or treatment that the child needs
- Work with patient and family and other care providers to coordinate care

For more information, please reference this website: http://www.medicalhomeinfo.org/

By signing, I confirm that I have read and understand the PCMH Fact Sheet. (Parent/Legal Guardian signature if patient is under 18, Patient signature if 18+)

Parent/Guardian or Patient Full Name	Parent/Guardian or Patient Signature:	Today's Date:

West Ashley: 1871 Savage Road Charleston, S.C. 29407
Goose Creek: 105 Springhall Drive Goose Creek, S.C. 29445
Hanahan / North Charleston: 1818 Remount Road Hanahan, SC 29410
Phone: (843) 766-6308 Fax: 866-533-4473

Authorization for Release of Protected Health Information

Patient Full Name: _____	Date of Birth: _____
Street Address: _____	SSN: _____
City, State, Zip: _____	Best Contact #: _____
E-mail Address: _____	May we leave a message at this number? ☐Yes ☐No
RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:** **Neighbors Pediatrics**
Name of Facility, Person, or Company	Name of Facility, Person, or Company **1871 Savage Road, Charleston, SC 29407**
City, State, Zip	City, State, Zip **843-766-6308** **866-533-4473**
Phone Number Fax Number	Phone Number Fax Number

PURPOSE OF RELEASE: (Please select reason below)

☐Individual/Personal Use ☐Continued Patient Care ☐Relocation ☐Legal ☐Dissatisfaction with practice or provider

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From _____ To _____ or ☐ All

PHYSICIAN PRACTICE INFORMATION TO BE RELEASED: (Check all that apply)

☐Office/Clinic Summary (may include recent office visits, physical exam, consults, and diagnostic test results) Progress
☐Notes
☐Laboratory Reports Radiology
☐Reports
☐Other: _____
☐Entire Records (not including psychotherapy notes)

Fees May Apply. Requests for more than ten pages will be processed by our copy service. Charges that may apply pursuant to SC Code Section 44-115-80.

FORMAT	**DELIVERY METHOD** (check one)
☐Paper copy ☐Electronic (Secure Email or USB) We have limited capabilities for electronic transfers. We will contact you for details.	☐Reg. US Mail (Out of State only) ☐Pick-up ☐Fax, where permitted ☐Electronic (Secure E-mail or USB).

PATIENT RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be
- protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- Neighbors Pediatrics will not share or use my health information without my permission other than in ways listed in Neighbors Pediatrics Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available by request.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Print Name: Parent/Legal Gurdian/Patient Signature: Date:

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. If signature is not that of patients, written proof of relationship/authority will be required.

☐ Healthcare Agent/POA	☐ Guardian	☐Executor/Administrator/Attorney in Fact	☐ Spouse
☐ Parent	☐ Adult Child	☐ Affidavit/Next of Kin	☐ Other:_____

Neighbors Pediatrics
Patient & Family Medical History

Print Patient's Name	Date of Birth	Today's Date:

Patient Medical History

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

If no, please explain: _____

Besides birth, has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever had: (check if yes)

☐ A blood transfusion ☐ Convulsions or seizures ☐ Heart problems/murmur ☐ Major injuries

☐ Serious illnesses ☐ Surgeries ☐ Feeding or dietary problems ☐ Skin cancer/skin disorders

If yes, please explain: _____

Does your child have any: ☐ Food Allergies ☐ Drug Allergies

If yes, please explain: _____

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

Mental: _____

Physical: _____

Social/Emotional: _____

Has your child ever experienced any of the following:

☐ Abdominal pain ☐ Bronchitis/Pneumonia ☐ Bedwetting 5+ years ☐ Bladder/kidney infection

☐ Chicken pox ☐ Reoccurring skin problems ☐ Diabetes ☐ Prolonged fevers

☐ Frequent ear infections ☐ Headaches ☐ Lung/breathing issues ☐ Nasal allergies

☐ Problems with ears/hearing ☐ Problems with eyes/vision ☐ Wheezing/asthma ☐ Ongoing constipation

If yes, please explain: _____

Do you have concerns about your child's weight? ☐ Yes ☐ No

If yes, please explain: _____

Does your child routinely engage in physical activity? ☐ Yes ☐ No

If yes, please explain: _____

List any medications that your child is currently taking. Please include dosage, frequency, and reason for taking.

_____

_____

_____

Please explain any other medical or social history that you consider important for us to best care for your child.

_____

_____

_____

_____

Family Medical History

Note: The family medical history section is not required and may be left blank if patient is adopted or a foster child.

Has anyone in your close family (parents, sister, brother, grandparent, aunt, uncle, etc.) experienced the following:

□ Alcoholism	□ Allergy or sinus problems	□ Anemia	□ Arthritis
□ Asthma	□ Bleeding problems	□ Bronchitis	□ Cancer or leukemia
□ Diabetes	□ Hearing Problems	□ Heart attack	□ High blood pressure
□ Intestinal Problems	□ Kidney problems	□ Intellectual disability	□ Psychiatric illness
□ Seizures	□ Sickle cell	□ Thyroid problems	□ Tuberculosis
□ Ulcers	□ Vision problems	□ Skin cancer or melanoma	□ Arthritis

If yes, please explain :

Please list any other family medical history that you consider important to share with us:

I certify that the above information is correct and true to the best of my knowledge.

Print Patient's Name	Patient's Signature (if 16 years or older)	Today's Date
Print Legal Guardian Name:	Legal Guardian Signature:	Relationship to Patient