Quail Ridge Family Practice, LLC
1 Doctors Park – Cairo, GA 39828
Phone 229-378-8110   Fax 229-378-8109

Patient Information

Patient Name **Date of Birth** **Age**

Home Address **City** **State** **ZIP**

Preferred (alternate) Mailing Address **City** **State** **ZIP**

Contact Phone Numbers: ****Circle the phone number you prefer us to use. ** Check the box if it is okay to leave a message.**

Home Phone ☐ Okay to leave a message **Work Phone** ☐ Okay to leave a message **Cell Phone** ☐ Okay to leave a message

Patient E-mail Address **Pharmacy**

Sex ☐ Male ☐ Female **Language** ☐ English ☐ Spanish ☐ Other ________________

Social Security Number **Driver's License Number**

RACE
☐White ☐Hispanic ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Asian ☐American Indian/Alaska Native ☐ Other

ETHNICITY
☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Other

MARITAL STATUS
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Employer/School **Occupation**

Employer Address **City** **State** **ZIP**

Employer Phone

Spouse's Name **Spouse's Employer**

Previous Physician's Name **Whom may we thank for referring you to our practice?**

Do you have a living will? Yes ____ No ____ (If yes, please provide us with a copy)

Responsible Party Information - For Payment (Parent/Guardian if patient is under 18 years of age)

Name **Date of Birth** **Relationship to Patient**

Address **City** **State** **ZIP**

Home Phone **Work Phone** **Cell Phone**

Social Security Number (for insurance purposes only)

Emergency Contact

Name **Relationship to Patient**

Address **City** **State** **ZIP**

Home Phone **Work Phone** **Cell Phone**

Name of Nearest Relative (not living with patient) **Relationship to Patient**

Home Phone **Work Phone** **Cell Phone**

Signature ____ **Today's Date** ______/______/______

Quail Ridge Family Practice, LLC

Mark C Hudson, DO, FAAFP
1 Doctors Park
Cairo, GA 39828

Phone 229-378-8110
Fax 229-378-8109

PEDIATRIC HISTORY QUESTIONNAIRE

Name: ____ Age: ________ DOB: __________ Today's Date: ___________
Address: ______________________________________ Parents' Names: ____
______________________________________ ____
Phone: ____ Legal Guardian: ____

MEDICAL PROBLEMS:	MEDICATIONS:	HOSPITALIZATIONS / SURGERIES / DATE:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

BIRTH HISTORY:	FEEDING / NUTRITION:
Problems with mother's pregnancy?	Any unusual feeding problems?
Birth Weight	
Did mother smoke or drink alcohol during pregnancy?	Any problem with diarrhea or constipation?
Did mother take any medications during pregnancy?	Is the child's drinking water city or well water?
Did mother use any recreational drugs in pregnancy?	Is the water fluoridated?
How many weeks gestation was mother when baby	How many meals does the child eat per day?
was born?	How many snacks?
Any problems during labor or delivery?	Does the child take vitamins? fluoride? Iron?
Was the baby delivery by c-section or vaginally?	Was (is) the child breastfed? How long?
Any problems during the nursery stay?	What type (if any) infant formula used?
How long did baby stay in hospital? Mother?	What age was bottle discontinued?
Any problems for baby or mother within 2 months	At what age did baby eat first solid food?
of birth? If so, what?	Does (did) baby have a pacifier?

ALLERGIES (list any allergies child has, including any allergic reactions to medications)

IMMUNIZATIONS: Is child up to date? (Please supply record of any previous immunizations)

CHILD CARE / SCHOOL: Is child in school or a day care center? Where?

If not, who is (are) child's primary caretaker(s) during the day? In the evenings? Weekends?

MEDICAL / FAMILY HISTORY (Please mark if child or members of the child's family –- parents, siblings, grandparents, aunts, uncles --- have had any of the following illnesses or problems.

	Child	Family		Child	Family
Frequent ear infection			Kidney / bladder problems		
Frequent colds, sore throats			Seizures / convulsions		
Croup			Early heart disease (age < 65)		
Mumps, measles, chicken pox			High blood pressure		
Wheezing or asthma			High cholesterol		
Pneumonia			Lung disease / tuberculosis		
Eye problems			Sexually transmitted disease		
Dental problems			Alcohol / drug abuse		
Hearing problems			Emotional problems / suicide attempts		
Hayfever			Cancer		
Eczema / skin problems			Other illnesses (list)		
Anemia / blood problems					

PEDIATRIC HISTORY (continued) Name: ____________________________ DOB: ___________________

DEVELOPMENT AND BEHAVIOR:	HEALTH AND SAFETY:
Did child sit alone by 7 months?	Are there guns in the child's house?
Did the child walk alone by 14 months?	How often does the child use a toothbrush?
Did the child say 3 words by 15 months?	Does the child always use a car seat or seatbelt?
Is the child doing well in school?	Are there smoke detectors in the child's home?
Does the child get along well with other children?	Is the hot water heater set less than 125 degrees?
Check off any of the following problems the child has:	Do you have rules / limits for television viewing?
☐ Nightmares / sleep problems	Are medicines and poisons out of reach?
☐ Irritable / bad temper	Do you have syrup of Ipecac?
☐ Discipline problems	Do all of child's caretakers know child resuscitation or
☐ Speech problems	choking management?
☐ Thumbsucking	Is there a pool or other body of water at or near
☐ Bedwetting	child's home? Can child swim?
☐ Toilet training problems	Does child wear a bicycle helmet?
☐ Breath holding	Do you have a thermometer in the child's home?

SOCIAL HISTORY:

1. Please list all household members, ages, relationship to child, and general health:

Name	Age	Relationship	General Health

2. Please list any family members not living in the same household as the child:

Name	Age	Relationship	General Health

3. Parents' and /or guardians' education and occupations:

4. Has the child ever experienced any traumatic event, such as loss of a loved one, divorce, serious accident, etc?

5. What activities does the child particularly enjoy?

6. What activities does the child particularly dislike?

____ ______________________

Signature of Parent / Legal Guardian *Date*

Quail Ridge Family Practice, LLC
1 Doctors Park – Cairo, GA 39828
Phone 229-378-8110   Fax 229-378-8109

Insurance Information	
Primary Insurance	**Secondary Insurance**
Subscriber Name ______________________________________	Subscriber Name ______________________________________
Social Security Number _________________________________	Social Security Number _________________________________
Date of Birth ____	Date of Birth ____
Insurance Company ____________________________________	Insurance Company ____________________________________
Insurance ID# ____	Insurance ID# ____
Group # ____	Group # ____

Authorization for Treatment / Release of Information / Assignment of Insurance Benefits

The undersigned hereby grants authorization for such treatments and procedures that are deemed necessary and understands that such treatments and procedures may be performed by physicians, nurse practitioners, physician assistants. I hereby authorize Quail Ridge Family Practice to release all protected health information necessary to secure payment, to carry out treatment, and to carry out health care operations.

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company.
I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Quail Ridge Family Practice, LLC. I will be held financially responsible for any non-covered benefits, deductibles or any co-payments for services which have been provided to me. I understand that I am financially responsible for all charges whether or not paid by said insurance. ***It is my responsibility to understand my insurance benefits and plan coverage.***

This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original.

Payment is expected at the time services are rendered.

____   ____________________________
Signature of Patient / Legal Representative   Date