MIAMI COUNTY PUBLIC HEALTH
WELL CHILD CLINIC

DATE: _____

NAME: (FIRST) _____ (MIDDLE) _____ (LAST) _____

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: M F RACE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: (____) _____ ALTERNATE PHONE: (____) _____

HMO PLAN: _____ HMO/MEDICAID #_____

SOCIAL SECURITY NUMBER: _____ (Do not know _____)

MOTHER'S NAME: _____ AGE: ____ MARRIED/SINGLE/SEPARATED/DIVORCED/WIDOW

MOTHER'S OCCUPATION: _____ MOTHER'S SOCIAL SECURITY NUMBER: _____

FATHER'S NAME: _____ AGE: ____ MARRIED/SINGLE/SEPARATED/DIVORCED/WIDOW

FATHER'S OCCUPATION: _____ FATHER'S SOCIAL SECURITY NUMBER: _____

FAMILY PHYSICIAN: _____ FAMILY DENTIST: _____

PREFERED PHARMACY: _____

Updated (Date and Initials):

(This section to be completed at clinic appointment)

Acknowledgment of Notice of Health Information Privacy Practices

I hereby acknowledge notification of Miami County Health District's Notice of Health Information Privacy Practices. A copy is available upon request. Please print your name, sign and date as indicated below:

Name:(please print)_____

Signature:_____ Date:_____

(A copy of the acknowledgment will be kept in your patient file.)

Rev.11/08 tw; 11/19/12 MC; 2/16/17 lrh

Self –Declaration of Income

My HOUSEHOLD'S gross income (income before taxes) is $_____(week/month)

We receive$_____child support (week/month)

We receive $_____cash assistance from Dept. of Jobs and Family Services.

We receive$_____Social Security Benefits

*If you have recently become employed and do not have a pay stub on which to base your monthly income, please list your hourly rate, how many hours per week what you work, and how often you will be paid. We can project your gross monthly income.

I will be paid $_____per hour_____I expect to work_____hours per week.

I will be paid weekly/ bi-weekly/monthly (please circle)

My spouse (or significant other) will be paid weekly/ bi-weekly/monthly

Hourly rate $____x_____hours worked = $_____

____I have private insurance. Please provide a copy of your insurance card.

____I have Medicaid/Caresource/Buckeye/Paramount/UHC Community Plan/Molina. Please provide a copy of your insurance card.

____I do not with to disclose my household income, I understand that I must pay 100% of the charges at the time of services.

I verify that the information I have provided is correct to the best of my knowledge. Program officials may verify the information on this form. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution. I hereby acknowledge receiving a copy of this form if requested.

SIGNATURE_____DATE_____

WITNESS_____DATE_____

Miami County Well Child Clinic Consent for Treatment

Child's Name: _____

Address: _____

Date of Birth: _____ Phone: _____

I hereby give my permission for the above-named child to have all examinations, immunizations, laboratory tests, medications, and/or treatments from physicians, nurse practitioners, nurses, dentists, and other health personnel of the Miami County Well Child Clinic which may be deemed necessary.

In addition, I hereby give my permission to the Miami County Well Child Clinic to release the medical records of the above named child to any health care agency to which the child may be referred and I hereby release the Miami County Well Child Clinic from and liability for the same.

I also hereby give permission to any doctor, dentist, psychologist, school, medical, dental, mental health, or social service agency to release and records concerning the above named child to the Miami County Well Child Clinic when such records are requested by the clinic.

Signature: _____ Date: _____

Relationship: _____

Rev. 9/24/13 lrh

Miami County Well Child Clinic
Health History Form
Birth through 5 years

Today's date: _____

Child's Name: _____ Sex: M F Date of birth: _____

Your name: _____ Relationship to child: _____

Birth History:

Baby was born: ☐ On time ☐ Early _____weeks ☐ Overdue _____weeks

Baby was delivered by the following method: ☐ Vaginal birth ☐ Caesarean section

Were there any problems during or after the birth? _____

Mother's health habits during the pregnancy: ☐ Smoking ☐ Alcohol use ☐ Drug use

Did the mother receive prenatal care? ☐ Yes ☐ No Mother's age when the baby was born: _____

Did the baby have to stay in the special care nursery? ☐ Yes ☐ No

Baby's birth weight: _____ Baby's birth length: _____

Child Breastfed? ☐ Currently ☐ Never ☐ Ever (For how long? _____)

Child's Medical History: (Check all that apply)

Has the child ever had any of the following? ☐ None

☐ Heart disease ☐ Ear infections ☐ Pneumonia ☐ ADHD ☐ Seizures

☐ Asthma ☐ Scarlet fever ☐ Chickenpox ☐ Meningitis

☐ Allergies (food, drugs, environmental) _____

☐ Other_____

Family Medical History: (Check all that apply)

Do any blood-related relatives have any of these conditions or disease? ☐ None

☐ High blood pressure ☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Thyroid problems

☐ Cancer ☐ Birth defects ☐ Seizures ☐ Liver disease ☐ Kidney disease

☐ Headaches ☐ Blood disorders ☐ Arthritis ☐ Tuberculosis ☐ Mental Illness

☐ Other_____

Medications:

List all medications your child is currently taking: ☐ None

Medication: _____For:_____ Date started: _____

Medication: _____For:_____ Date started: _____

Medication: _____For:_____ Date started: _____

Has your child been on any medication(s) that were recently discontinued? ☐Yes _____

☐No

Hospitalizations or Surgeries:

List any hospitalizations or surgeries your child has ever had: ☐ None

Type of surgery: _____Hospital:_____Date:_____

Type of surgery: _____Hospital:_____Date:_____

Type of surgery: _____Hospital:_____Date:_____

Miami County Well Child Clinic
Health History Form
6-12 years

Today's Date: _____

Child's Name: _____ Sex: M F Date of Birth: _____

Your Name: _____ Relationship to child: _____

Child's Medical History

Has your child ever had any of the following conditions? Check all that apply.

	Asthma		Heart Disease
	ADHA		Ear Infections
	Seizures		Scarlet Fever
	Pneumonia		Chickenpox
	Allergies (environmental, food, drug)		Meningitis
	Other:		

Check here if none

Family Medical History

Do any blood-related relatives have any of these conditions or diseases? Check all that apply.

	High Blood Pressure		Heart Disease
	Birth Defects		Blood Disorders
	Seizures		Kidney Disease
	Arthritis		Diabetes
	Headaches		Mental Illness
	Liver Disease		Stroke
	Thyroid Problems		Cancer
	Other:		

Check here if none

Medications

List all medications your child is currently taking:

N/A

Medication:_____For:_____Date started:_____
Medication:_____For:_____Date started:_____
Medication:_____For:_____Date started:_____

Has your child been taking any medications that were recently discontinued? YES NO _____

Hospitalizations or Surgeries

List any hospitalizations or surgeries your child has ever had:

N/A

Type of surgery: _____ Hospital: _____ Date: _____
Type of surgery: _____ Hospital: _____ Date: _____
Type of surgery: _____ Hospital: _____ Date: _____

School History

What grade is your child in? _____
Does your child enjoy school? ___Yes ____No
How is your child doing in school? ___below average ___average ___above average
Do you have any concerns about your child behavior at school? ___Yes ___No
Does your child have after school supervision? ___Yes ___No
Does your child participate in after school activities or spots? ___Yes ___No
List_____

Miami County Well Child Clinic
Health History Form
13-21 Years

Today's Date: _____

Child's Name: _____ Sex: M F Date of Birth: _____

Your Name: _____ Relationship to child: _____

CHILD'S MEDICAL HISTORY

Has your child ever had any of the following conditions? Check all that apply.

	Asthma		Heart Disease
	ADHA		Ear Infections
	Seizures		Scarlet Fever
	Pneumonia		Chickenpox
	Allergies (environmental, food, drug)		Meningitis
	Other:		

☐ Check here if none

FAMILY MEDICAL HISTORY

Do any blood-related relatives have any of these conditions or diseases? Check all that apply.

	High Blood Pressure		Heart Disease
	Birth Defects		Blood Disorders
	Seizures		Kidney Disease
	Arthritis		Diabetes
	Headaches		Mental Illness
	Liver Disease		Stroke
	Thyroid Problems		Cancer
	Other:		

☐ Check here if none

Medications

List all medications your child is currently taking:

☐ N/A

Medication:_____For:_____Date started:_____
Medication:_____For:_____Date started:_____
Medication:_____For:_____Date started:_____

Has your child been taking any medications that were recently discontinued? YES NO _____

Hospitalizations or Surgeries

List any hospitalizations or surgeries your child has ever had:

☐ N/A

Type of surgery: _____ Hospital: _____ Date: _____
Type of surgery: _____ Hospital: _____ Date: _____
Type of surgery: _____ Hospital: _____ Date: _____

School History

What grade is your child in? _____
Does your child enjoy school? ___Yes ____No
How is your child doing in school? ___below average ___average ___above average
Do you have any concerns about your child behavior at school? ___Yes ___No
Does your child have after school supervision? ___Yes ___No
Does your child participate in after school activities or spots? ___Yes ___No
List_____