



REGISTRATION FORM - PEDIATRIC

Choose an item.

Today's Date:		PCP:	
PATIENT INFORMATION			
Patient's Legal Last Name:		First:	Middle:
Previous Names Used/Alias:	Birth Date: / /	Age:	Social Security #:
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Intersex <input type="checkbox"/> Not recorded on birth certificate			
Parent 1 Name:	Cell Phone:	Work Phone:	
Parent 2 Name:	Cell Phone:	Work Phone:	
Mailing Address:		City:	State: Zip:
Parent 1 Email Address:		Parent 2 Email Address:	
Best way to contact for results, follow up, or scheduling? (check all that apply)			
<input type="checkbox"/> Parent 1 Cell <input type="checkbox"/> Parent 1 Work <input type="checkbox"/> Parent 2 Cell <input type="checkbox"/> Parent 2 Work <input type="checkbox"/> Parent 1 Email <input type="checkbox"/> Parent 2 Email			
Child's Race: <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> White			Child's Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose
Child's Sexual Orientation: <input type="checkbox"/> Asexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Omnisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Queer <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose	Child's Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female / Male-to-Female <input type="checkbox"/> Transgender Male / Female-to-Male <input type="checkbox"/> Non-Binary/Genderqueer <input type="checkbox"/> Questioning <input type="checkbox"/> Two Spirit <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____	Child's Preferred Pronoun: <input type="checkbox"/> she/her/hers <input type="checkbox"/> he/him/his <input type="checkbox"/> they/them/theirs <input type="checkbox"/> patient's name <input type="checkbox"/> Ze/hir/hirs <input type="checkbox"/> ey/em/eirs <input type="checkbox"/> xe/xem/xyrs <input type="checkbox"/> Decline to answer <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	
IN CASE OF EMERGENCY			
Name:	Relationship to Patient:	Phone Number:	Okay to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No
LANGUAGE			
What language do you speak at your home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No Preferred: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No Preference	

(turn page over to finish reading and sign this registration form)

RESPONSIBLE PARTY

If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Parent/Legal Guardian Responsible for Bill:	Birth Date: / /	Social Security # of Parent/Legal Guardian:	
Mailing Address: <input type="checkbox"/> Same as above	City:	State:	Zip:
Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work			

ADDITIONAL INFORMATION

Homeless Status: <input type="checkbox"/> Not Homeless <input type="checkbox"/> Living with Others <input type="checkbox"/> Street, Camp, Bridge <input type="checkbox"/> At Risk for Homeless <input type="checkbox"/> Homeless, Unknown Shelter <input type="checkbox"/> Currently Not Homeless, Was in the Last 12 Months <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Living in Shelter <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Veteran at Risk for Homeless <input type="checkbox"/> Child at Risk for Homeless <input type="checkbox"/> Single Occupancy Hotel		
Farm Work Recognition: Are you or someone in your household involved in a type of farm work that may include: soil prepping, planting, picking, cleaning, sorting, packing, Christmas tree farming? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Migrant – You or a member of your household has established a temporary home in order to do farm work <input type="checkbox"/> Seasonal – You or a member of your household do farm work that only happens at certain times throughout the year		Parent Veteran status: <input type="checkbox"/> Active Duty <input type="checkbox"/> Inactive Duty <input type="checkbox"/> No previous experience <input type="checkbox"/> Reservist <input type="checkbox"/> Uncollected <input type="checkbox"/> Veteran
Number of Family Members:	Monthly Income (before taxes) \$:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neighborhood Health Center or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

FOR OFFICE USE ONLY

Initials for Special Confidentiality: _____ Screen By: _____ Total Income: \$ _____

TITLE X: Clients pay _____ % per sliding fee scale for non-FPEP covered service.

Address Verification: Yes Date/Initials _____ Patient declined confidentiality



COMBINED CONSENT FORM

Patient Name

Patient Date of Birth (DOB)

TREATMENT AND FINANCIAL

I authorize treatment of the person named above and accept financial responsibility for all treatment, including any necessary or recommended vaccines provided. I authorize Neighborhood Health Center to provide to my insurance companies all information necessary to process insurance claims and assign Neighborhood Health Center all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy or scanned image of this authorization shall be considered as valid as the original.

ACKNOWLEDGMENT OF HIPAA NOTICE

I acknowledge receipt of Neighborhood Health Center's Notice of Privacy Practices.

PATIENT CENTERED PRIMARY CARE HOME CONSENT

Your primary care home will; better coordinate our care to help get you the services you need, listen to your concerns and answer your questions, offer after-hours help and alternatives to the emergency room, help you play an active role in your health. I have read and understand the information on Patient Centered Primary Care Home and consent to be a part of the Neighborhood Health Center Medical Home.

REPRODUCTIVE HEALTH SERVICES

When seeking reproductive health services from Neighborhood Health Center I understand that I am receiving these services voluntarily.

I understand that these services may include:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies, and other subjects as needed;
- Providing a birth control method;
- A provider visit for a prescription and maybe a physical exam;
- Testing and/or treatment for sexually transmitted infections (STIs);
- Testing for cervical cancer, pregnancy and/or other health problems; and
- Referrals to other services, if needed.

I understand that all services will be explained and I can ask questions.

I understand I may be given information about birth control methods. I can ask questions and refuse any birth control method I do not want to use.

I understand that I won't be refused care if I owe money from other visits.

(turn page over to finish reading and sign this consent form)

I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.

I understand that the services I receive and my medical records are private, except:

- If a judge issues a subpoena for my records, Neighborhood Health Center is required by law to give the records to the court.
- If I have reportable disease, Neighborhood Health Center will be required to report it to Oregon State Public Health.
- The State of Oregon requires all Neighborhood Health Center Staff to report any abuse of vulnerable individuals, which includes children, elders, persons who are mentally ill, developmentally disabled, or living in a long term care facility to The Department of Human Services that is witnessed or learned of inside or outside of a Neighborhood Health Center Clinic.
- I understand I may choose not to talk about sensitive information, such as the age(s) of sex partner(s), and that I will still get services.

I understand that if I get reproductive health services here, I can still apply for or get services from other programs. If I get care from other programs, I can still get services at Neighborhood Health Center.

DENTAL SERVICES

I understand that Neighborhood Health Center partners with different academic institutions and that I may be treated by a student/extern practicing under the direct supervision of a licensed professional at Neighborhood Health Center. I authorize Neighborhood Health Center professionals and their partners to provide such treatment and this authorization shall remain in effect until revoked in writing.

Patient Signature

Date

Signature of Patient's Representative (If patient is under 18)

Date

Relationship of Representative



COMMUNICATION PERMISSIONS FOR PROTECTED HEALTH INFORMATION (PHI)

Patients who are minors (under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by NHC staff.

Patient Name:	Date of Birth:
IT IS OK FOR NEIGHBORHOOD HEALTH CENTER TO CONTACT YOU? (please check all that apply):	
1. Can we send bills to your address?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Can we send automated appointment reminders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which type?	<input type="checkbox"/> Phone call <input type="checkbox"/> Text message
3. Can we send you newsletters via email?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Can we call you regarding your visit/treatment with us? Types of calls that could be made:	
Primary Care (lab Results, medical instructions, referrals, medications, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Health (follow up on concerns, referrals, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reproductive Health (sexual health, STI treatment, test results)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Communication: <input type="checkbox"/> Do not contact <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email via MyChart <input type="checkbox"/> No preference <input type="checkbox"/> Text	
WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE? (NOTE: this is not an authorization to release records):	
I authorize Neighborhood Health Center to speak to the following people, in person or by telephone: <input type="checkbox"/> Not Applicable	
Name:	Relationship:
Home #:	Work #: Mobile #:
Preferred Language:	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Use this person as an emergency contact	<input type="checkbox"/> Authorized to sign on behalf of guardian in guardian's absence
Regarding (please check all that apply):	<input type="checkbox"/> Schedule / cancel appointment <input type="checkbox"/> Medical instruction / advice
<input type="checkbox"/> Prescription drug information	<input type="checkbox"/> Lab results <input type="checkbox"/> Imaging results
<input type="checkbox"/> All information	<input type="checkbox"/> Other:
Name:	Relationship:
Home #:	Work #: Mobile #:
Preferred Language:	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Use this person as an emergency contact	<input type="checkbox"/> Authorized to sign on behalf of guardian in guardian's absence
Regarding (please check all that apply):	<input type="checkbox"/> Schedule / cancel appointment <input type="checkbox"/> Medical instruction / advice
<input type="checkbox"/> Prescription drug information	<input type="checkbox"/> Lab results <input type="checkbox"/> Imaging results
<input type="checkbox"/> All information	<input type="checkbox"/> Other:
PLEASE LIST LEGAL REPRESENTATIVE, GUARDIAN, POWER OF ATTORNEY, ETC. IF ANY (please provide proof)	
Name: _____	<input type="checkbox"/> Not Applicable
Relationship: _____	Phone: _____
SIGNATURE REQUIRED (below):	
The authorization may be changed or revoked in writing at any time. It will remain in effect until one (1) year from the date below. By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.	
Signature (Patient/Legal Guardian) _____	Date _____
Print Name _____	Relationship (if not patient) _____



SLIDING FEE DISCOUNT PROGRAM

APPLICATION

INSTRUCTIONS

1. In order to receive discounted services, all patients must apply annually for the Sliding Fee Discount Program. Eligibility is based on family size and household income, as it relates to current Federal Poverty Guidelines.
2. Please read the *Sliding Fee Discount Program Information* sheet. If you have additional questions, please ask the front desk.
3. Please fill out the application and return it to Neighborhood Health Center (NHC) with proof of income attached. Don't forget to sign and date your application.
4. If you can't attach proof of income to your application today, please return proof of income to NHC within 30 days of submitting this application.
5. List yourself as the first family member, followed by others. For individuals not earning an income (for example, a child within your family), enter zero (\$0) for their monthly income.

PERSONAL INFORMATION

Full Name	
Address	
Phone Number	
Today's Date	

FAMILY MEMBERS

- Family is defined as a group of two or more people living together who are financially supporting one another.
- Report \$0 under 'Monthly Income' for any family members who do not support you financially.

Full Name	Date of Birth	Relationship	Monthly Income (before taxes)
		Self	\$
			\$
			\$
			\$
			\$
			\$
			\$

IF YOU REPORT ZERO FAMILY INCOME OR A SOURCE OF INCOME THAT CANNOT BE PROVED

How long have you been without a taxable source of income?	<input type="checkbox"/> > 6 months <input type="checkbox"/> 6 months-1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> Over 2 years
Why are you unable to provide proof of income?	

ATTESTATIONS

Please read and initial next to each attestation

	I attest that I have read the <i>Sliding Fee Discount Program Information</i> sheet and understand requirements to participate in the program.
	I understand that discount will not be applied until my application <u>and</u> proof of income are reviewed and accepted by NHC. I understand that if I cannot provide proof of income, discount will not be applied until my request to waive proof of income is reviewed and approved by NHC's Chief Operating Officer or their designee.
	I understand that eligibility in the program is valid one year from the date my application is approved. I understand I must reapply each year to remain in the program.
	I understand that should my income or family size change during my one-year period of eligibility, I will report changes to NHC and reapply for the program.
	I understand that should my insurance prohibit a waiver of my co-pay, the full co-pay will be collected at the time of service. If you are unsure, contact your insurance company.

SIGNATURE

I certify that the information stated is true and accurate by signing this form. If false information is used to obtain assistance, I will be removed from the sliding fee discount program.

Applicant Signature	Date



-----DO NOT WRITE BELOW THIS LINE-----

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Applicant/s Information	
Patient/s MRN	
Monthly Family Income (from table on pg.1)	\$
Family Size (from table on pg.1)	
Proof of Income Status at Time of Application	<input type="checkbox"/> A. Yes, proof attached <input type="checkbox"/> B. Pending, 30-day grace period <input type="checkbox"/> C. No, applicant has listed zero or cash source of income, pending approval by COO or designee
Date	
Reviewed By	

Proof of Income Status: A or B	
Monthly Family Income (verified by proof)	\$
Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
Date Verified	
Reviewed By	
Proof of Income Status: C	
Decision	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
Date of Review	
Signature of COO or Designee	



SLIDING FEE DISCOUNT PROGRAM INFORMATION

WHY SHOULD I SIGN UP FOR THE PROGRAM?

Neighborhood Health Center (NHC) offers discounted services to patients living at or below 200% of the most current Federal Poverty Guidelines (FPG). Eligibility to participate in the program is based only on the patient's household income and family size, as it relates to FPGs. All patients are encouraged to apply, including patients with insurance. Discounts apply to all NHC services provided directly at NHC clinics and those offered in referral. Discounts vary depending on the patient's assigned discount pay class (see Discount Classes A-D in the Monthly Income table below) and the service being used by the patient at the time of appointment (i.e. medical, dental, or behavioral health). Please take a moment to review this information sheet prior to filling out your application. If you have questions, please ask an NHC staff member for assistance.

WHO SHOULD I INCLUDE IN MY FAMILY SIZE?



NHC defines a family as a group of two or more people living together who are financially supporting one another.

Do NOT include:

- Family members who do not live with you
- Family members who are financially independent

Still not sure who to include? Ask us!

WHAT IS ACCEPTABLE PROOF OF INCOME?

For each member contributing income to the family, attach at least one of the following documents to your application:

- ✓ Two (2) weeks of most recent pay stubs
- ✓ Check stubs from Unemployment Insurance
- ✓ Previous year W-2
- ✓ Previous year completed tax return
- ✓ Government-issued documentation for other non-wage income such as Social Security, Worker's Comp, Cash Assistance, Child Support, Alimony, Veteran's Benefits, Retirement, or Pension
- ✓ Previous three (3) months of bank statements
- ✓ Letter from employer
- ✓ If self-employed: prior year tax return or most recent three (3) months of bank statements

WHAT DISCOUNT WILL I RECEIVE?

Below is a table displaying the 2021 Federal Poverty Guidelines (FPG). Only patients reporting a family income at or below 200% of FPG will qualify. Columns A through D are eligible for discounted services. Column E (above 200% FPG) must pay in full for charges and will not receive a discount. If you fall within Column E, you are not eligible to participate in the program.

		MONTHLY INCOME									
Discount Class		A		B		C		D		E	
FPG		0-100%		>100-133%		>133-166%		>166-200%		>200%	
Family Size	1	\$0	\$1,073	\$1,074	\$1,428	\$1,429	\$1,782	\$1,783	\$2,147	\$2,148	& Up
	2	\$0	\$1,452	\$1,453	\$1,931	\$1,932	\$2,410	\$2,411	\$2,903	\$2,904	& Up
	3	\$0	\$1,830	\$1,831	\$2,434	\$2,435	\$3,038	\$3,039	\$3,660	\$3,661	& Up
	4	\$0	\$2,208	\$2,209	\$2,937	\$2,938	\$3,666	\$3,667	\$4,417	\$4,418	& Up
	5	\$0	\$2,587	\$2,588	\$3,440	\$3,441	\$4,294	\$4,295	\$5,173	\$5,174	& Up
	6	\$0	\$2,965	\$2,966	\$3,943	\$3,944	\$4,922	\$4,923	\$5,930	\$5,931	& Up
	7	\$0	\$3,343	\$3,344	\$4,447	\$4,448	\$5,550	\$5,551	\$6,687	\$6,688	& Up
	8	\$0	\$3,722	\$3,723	\$4,950	\$4,951	\$6,178	\$6,179	\$7,443	\$7,444	& Up
	9	\$0	\$4,100	\$4,101	\$5,453	\$5,454	\$6,806	\$6,807	\$8,200	\$8,201	& Up
	10	\$0	\$4,478	\$4,479	\$5,956	\$5,957	\$7,434	\$7,435	\$8,957	\$8,958	& Up

FPG: Federal Poverty Guidelines, published by HHS, effective 1/13/2021
For families/households with more than 10 persons, add \$378 for each additional person

EXAMPLE 1

Susan is a single mother of two young children, Susan also cares for her mother, who lives with her and her children. Susan's family size is 4. Susan is the only person in her family earning income. Susan earns \$2,600 per month in income. Susan belongs to Discount Class B.

EXAMPLE 2

Jose is married to his wife Miranda. They have three young children who live with them. Jose earns \$2,300 per month at his job. Jose's wife earns \$2,700 per month. Together, the couple earns \$5,000 per month. Jose's family size is 5. Jose belongs to Discount Class D.

WHAT AM I RESPONSIBLE TO PAY?

Once you figure out what Discount Class you belong to (A-D), discounts vary depending on the service you are using at the time of your service. Services are broken into groups and include medical, dental, and behavioral health.

Discounts apply to clinical services. Note that dental and pharmacy supplies and equipment have separate discounts because they are not clinical services.

	A	B	C	D	E
Medical & Clinical Pharmacy Services	\$25	\$35	\$40	\$45	100% of Full Charges
Dental Services*	\$25	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Dental Supplies & Equipment*	50% of Full Charges	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Behavioral Health & Psychiatry Services	\$5	\$10	\$15	\$20	100% of Full Charges
Pharmacy Dispensed Prescription Fees**	\$5 Dispensing Fee + Discounted Medication Cost	\$8 Dispensing Fee + Discounted Medication Cost	\$10 Dispensing Fee + Discounted Medication Cost	\$12 Dispensing Fee + Discounted Medication Cost	100% of Full Charges

*\$25 payment expected at the time of service.

**Ask your Pharmacist for a quote on your medications. Call 503-941-3160 for more information.

EXAMPLE 1

I belong to Discount Class B. I came in today for a medical visit with my Doctor. I am responsible to pay \$35 for my visit. The remainder of my charges will be adjusted by NHC so that \$35 is my only responsibility.

EXAMPLE 2

I belong to Discount Class C. I came in today for a dental exam and cleaning. The total of these charges was \$300. I am responsible to pay 60% of these charges. The remainder of my charges will be adjusted by NHC so that \$180 is my only responsibility (\$180 = 60% of \$300 charges).

EXAMPLE 3

I belong to Discount Class A. I came in today for an appointment to discuss my diabetes with a behaviorist. I am responsible to pay \$5 for my visit. The remainder of my charges will be adjusted by NHC so that \$5 is my only responsibility.

EXAMPLE 4

I belong to Discount Class D. I am diabetic and NHC is going to deliver my insulin medication to my home. My pharmacist told me I will pay a total of \$16 for my insulin. This includes the cost for the medication plus the dispensing fee.



I NEED MORE INFORMATION

Not sure who to include in your family size? Not sure what to bring to prove your income? Not sure what discount class you will qualify for? Not sure what you will be charged for a specific service?

Ask the front desk staff at your NHC clinic to answer any additional questions you have.



PEDIATRIC NEW PATIENT HEALTH HISTORY (12-17 YRS)

Please take a few minutes to answer these questions. We are asking these questions because the answers may help us provide better care for your child and support for you.

Patient's Name: _____ DOB: _____

Name of person filling out form (if other than patient): _____

I am this adolescent's: Mother Father Grandparent Foster Parent Other: _____

Is your child taking any medication regularly? No Yes If yes, what: _____

Does your child have any allergies (medicine, foods)? No Yes If yes, to what: _____

Has your child been vaccinated? No Yes Where did your child receive prior vaccinations? _____

ADOLESCENT'S HEALTH PROBLEMS (Check box if your adolescent has had any of these)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bone/joint/muscle problem | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Heart Problem/ Murmur | <input type="checkbox"/> Seizures / Epilepsy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Concussion/head injury | <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney / Bladder Problem | <input type="checkbox"/> Toothache / Decay |
| <input type="checkbox"/> Bleeding problem | <input type="checkbox"/> Eye / Vision Problem | <input type="checkbox"/> Learning problem | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Urinary tract infection (UTI) |

Has your child ever been hospitalized or had surgery? No Yes When / why: _____

Was your child born early (premature)? No Yes If yes, how many weeks early? _____

Were there any problems during pregnancy or delivery? No Yes If yes, explain: _____

FAMILY MEDICAL HISTORY (Check if your adolescent's biological siblings, parents, or grandparents have had any of the following):

- | | Relationship to adolescent | | Relationship to adolescent |
|--|----------------------------|--|----------------------------|
| <input type="checkbox"/> Alcohol/drug problem | _____ | <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> Anxiety | _____ | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> High Cholesterol | _____ |
| <input type="checkbox"/> Autism | _____ | <input type="checkbox"/> Intellectual disability | _____ |
| <input type="checkbox"/> Birth defect | _____ | <input type="checkbox"/> Kidney disease | _____ |
| <input type="checkbox"/> Bleeding disorder | _____ | <input type="checkbox"/> Mental illness | _____ |
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Seasonal allergies | _____ |
| <input type="checkbox"/> Childhood hearing loss | _____ | <input type="checkbox"/> SIDS | _____ |
| <input type="checkbox"/> Developmental delay | _____ | <input type="checkbox"/> Stroke before age 50 | _____ |
| <input type="checkbox"/> Depression | _____ | <input type="checkbox"/> Thyroid problem | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Eczema | _____ | <input type="checkbox"/> Other: _____ | _____ |
| <input type="checkbox"/> Epilepsy/ Seizures | _____ | | _____ |
| <input type="checkbox"/> Heart problem before age 55 | _____ | | _____ |

Signature: _____

Date: _____