



Thank you for choosing Knoxville Pediatric Cardiology, PC as your and or you child(ren)'s health care provider. We are looking forward to meeting with you and/or your child(ren) and developing a sincere and professional relationship with you and your family as we evaluate your and/or your child(ren) cardiac concerns. We also invite you to visit our web-site [www.knoxvillepediatriccardiology.com](http://www.knoxvillepediatriccardiology.com)

We participate with many HMO, PPO, and POS insurance plans and we will file those insurance claims for you. Please remember that your insurance policy is a contract between you and your insurance company and that we are not a party to that contract. Therefore, financial responsibility for your and or your child(ren)'s treatment ultimately is yours.

You are responsible for all co-payments and deductibles at the time of service. If you have an insurance, which we do not participate with, it will be your responsibility to pay at the time of service unless payment arrangements are made in advance of treatment and filed yourself. Also, please note that the parent who brings the child to our office is responsible for the bill incurred, regardless of any divorce decree stating otherwise. Any account, which must be referred to a collection agency will have a service charge added. A service charge of \$20.00 will be added for any check drawn on insufficient funds.

It is vital that you take time to read, understand, complete, and sign all enclosed paperwork in this packet with as much detail as possible so that we can provide you the best possible care upon arrival for your appointment. Any questions or concerns can certainly be directed to us upon your arrival, however having completed as much of the paperwork as possible will certainly expedite your visit. The following explanations and requests for permission are helpful and necessary for us as we evaluate, treat, and process your and /or your child's visit to our office.

### Office Policy

If a patient is not seen in the office within a three year span they will be considered a new patient and charged accordingly.

Prescription refills should be requested during normal business hours only. It is not our policy to call in Prescriptions without the child being seen first, unless it is a prescription refill from a hospital admission.

We do request at least 24 hours notice to reschedule or cancel an appointment. If scheduled appointments are missed on a continual basis without notification of cancellation this may result in the termination of care for yourself or your child(ren).

Signing below acknowledges that you have been given a copy of our office Privacy Policy.

The patient bill of rights is posted in the waiting room for all to read.

If you required a copy of your medical records, they can be picked up during normal business hours with 48 hours notice. Medical records may not be faxed.

Your signature below indicated that you understand these policies and authorize Knoxville Pediatric Cardiology, PC to provide you or your child(ren) with reasonable and proper medical care. In the event someone other than a parent brings the child(ren) to the office this also authorizes care in the absence of a parent.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

I, the undersigned also authorize Knoxville Pediatric Cardiology to leave a message on my answering machine concerning Lab/Test results and appointment dates.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

**KNOXVILLE PEDIATRIC CARDIOLOGY PC**  
**PATIENT HISTORY**

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:**        /        /        **REFERRING PHYSICIAN:** \_\_\_\_\_

Please describe why your Physician referred you/your child to our practice: \_\_\_\_\_

Please list all persons living in the home with the patient: \_\_\_\_\_

Smoking? : \_\_\_\_\_

**Please circle any of the following conditions the patient has experienced:**  
**(now or in the past)**

**Heart Murmur:**    YES    NO

**When was it first heard:** \_\_\_\_\_

**Chest Pain:**    YES    NO    (If Yes, Please Describe below)

**Frequency:** \_\_\_\_\_

**Duration:** \_\_\_\_\_

**Associated Symptoms:** \_\_\_\_\_

**Occur With Exercise:** \_\_\_\_\_

**Rapid/Difficult Breathing:**        YES    NO

**Colic:** \_\_\_\_\_        YES    NO

**Coughing/Wheezing:**        YES    NO

**Kidney Disease:** \_\_\_\_\_        YES    NO

**Pneumonia:**        YES    NO

**Blood in Urine:** \_\_\_\_\_        YES    NO

**Swollen Joints:**        YES    NO

**Convulsions/Seizures:**        YES    NO

**Excessive Sweating:**        YES    NO

**Bad Teeth:** \_\_\_\_\_        YES    NO

**Excessive irritability:**        YES    NO

**Nose Bleeds:** \_\_\_\_\_        YES    NO

**Easy Tiring with Exercise:**        YES    NO

**Headaches/Migraines:**        YES    NO

**Fainting/Passing out spells:**        YES    NO

**Kawasaki's Disease:** \_\_\_\_\_        YES    NO

**Rheumatic Fever:**        YES    NO

**Abnormal Heart Rate/Rhythm:**        YES    NO

**Swelling of Face, Hands, or Feet:**        YES    NO

**PAST MEDICAL HISTORY**

Please Describe the following conditions if relevant:

Serious Illnesses: \_\_\_\_\_

\_\_\_\_\_

Serious Injuries: \_\_\_\_\_

\_\_\_\_\_

Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

**Current Medication**

Medication	Dosage	Frequency
------------	--------	-----------

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any medication(s) your child is allergic to:

\_\_\_\_\_

\_\_\_\_\_

**Child Birth**

Birth Place: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Length of stay in Hospital: \_\_\_\_\_ Apnea or Cardiac Monitor: \_\_\_\_ YES NO

Gestational Age at Birth: \_\_\_\_\_ Problems During labor and/or Delivery: YES NO

Please Describe: \_\_\_\_\_

Prolonged Hospital Stay: YES NO

Please Describe: \_\_\_\_\_

Intensive Care Admission: YES NO

Please Describe: \_\_\_\_\_

**Infant Feeding History**

**Breast Fed: YES NO Formula Fed: YES NO Both: YES NO**

What Formula: \_\_\_\_\_

How Often: \_\_\_\_\_ Amount: \_\_\_\_\_ Duration: \_\_\_\_\_

Please Describe any feeding problems: \_\_\_\_\_

\_\_\_\_\_

**Child Development**

**Approximate age your child did each of the following:**

**Rolled Over:** \_\_\_\_\_ **Sat Alone** \_\_\_\_\_

**Walked Alone:** \_\_\_\_\_ **Speech Development:** \_\_\_\_\_

**Current Grade in School:** \_\_\_\_\_ **Any Failed Grades:** \_\_\_\_\_

**Learning Performance:**            **Fast**                            **Normal**                            **Slow**

**Strengths:** \_\_\_\_\_

**Weaknesses:** \_\_\_\_\_

**Biological Family History**

**Mother**

**Father**

**Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Tobacco Use:** \_\_\_\_\_

**Tobacco Use:** \_\_\_\_\_

**Alcohol Consumption:** \_\_\_\_\_

**Alcohol Consumption:** \_\_\_\_\_

**Serious Illnesses:** \_\_\_\_\_

**Serious Illnesses:** \_\_\_\_\_

**Pregnancies:** \_\_\_\_\_

**Premature Births:** \_\_\_\_\_

**PARENTS: (Please circle below)**

**Term Births:** \_\_\_\_\_

**Married    Divorced    Never Married**

**Misscarriages:** \_\_\_\_\_

**Any Children born with Congential Heart Disease:    YES            NO**

**Please Describe:** \_\_\_\_\_

\_\_\_\_\_

**Any Similar Symptoms experienced by other members of the Family:    YES            NO**

**Please Describe:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

