

# Demographic Information



Suburban Pediatrics  
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[www.suburbanpediatrics.com](http://www.suburbanpediatrics.com)

Ensuring the delivery of high-quality, patient-centered care requires understanding the needs of the populations served. In accordance with federal categories and definitions, insurance companies have adopted a policy that requires the collection and recording of race, ethnic background and language preference. Suburban Pediatrics understands the sensitive nature of this information and assures you that it is kept secure and confidential in accordance with all State and Federal privacy acts.

## >PATIENT

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Birth Mother's Maiden Name: \_\_\_\_\_

Patient Lives With (Name): \_\_\_\_\_ Relationship: \_\_\_\_\_

Does this patient live with both parents? YES: \_\_\_\_\_ NO: \_\_\_\_\_\*

\*If NO, please provide the Name/DOB/Phone # of the other parent:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Alt. Phone: (\_\_\_\_\_) \_\_\_\_\_

## >RESPONSIBLE PARTY

Name: \_\_\_\_\_ Primary Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone #: (\_\_\_\_\_) \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Alt Phone #: (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Marital Status: Never Married · Married · Domestic Partnership · Annulled · Divorced · Legally Separated · Widowed  
(Please Circle)

>PRIMARY PHYSICIAN: \_\_\_\_\_

PRIMARY INSURANCE	
Plan Name:	_____
Policy #:	_____
Group #:	_____
Eff. Date:	_____
Subscriber:	_____

SECONDARY INSURANCE	
Plan Name:	_____
Policy #:	_____
Group #:	_____
Eff. Date:	_____
Subscriber:	_____

## >EMERGENCY CONTACT

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

Phone #: (\_\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

## >PLEASE ANSWER THE FOLLOWING 3 QUESTIONS (Circle Your Response):

1. Race: White · Black/African American · Asian · Other (Please Specify): \_\_\_\_\_ Decline/Unknown
2. Ethnicity: Spanish/Hispanic Origin · Not of Spanish/Hispanic Origin · Decline/Unknown
3. Primary Language: English · Other (Please Specify): \_\_\_\_\_ · Decline/Unknown

>I have reviewed the above information, and confirm it to be accurate. I understand that I am financially responsible for charges not covered by my insurance carrier if I fail to follow the policies set forth in my insurance plan, or if charges are denied because my insurance coverage is cancelled or not in effect at the time services are provided.

Parent/Guardian Signature: \_\_\_\_\_

OFFICE USE ONLY	
Verified and entered:	_____
(Initials)	(Date)

## FAMILY MEDICAL HISTORY

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Please complete the following with the name of consultants for this child.

Dentist: \_\_\_\_\_ Eye doctor: \_\_\_\_\_

Gynecologist \_\_\_\_\_ Other: \_\_\_\_\_

**Check here if adopted.**     **Check here if there has been no change in any family history.**

Please check the box for any changes in medical history pertaining to the mother, father, siblings, (MGM) maternal grandmother, (MGF) maternal grandfather, (PGM) paternal grandmother or (PGF) paternal grandfather.

	Mother	Father	Siblings	MGM	MGF	PGM	PGF
Allergies							
Asthma							
Attention Deficit Disorder							
Autism/developmental issues							
Blood disorders/hemophilia							
Cancer (please specify type)							
Cardiac conditions (ie. murmurs, strokes, hypertension (please specify)							
Diabetes (please specify type)							
High Cholesterol							
Kidney Disease							
Mental Health/Substance Use (please specify)							
Obesity							
Strabismus (lazy eye)							
Stomach Issues (ie. Celiac/Crohns/IBD) (please specify)							
Thyroid disease							
Any other family history							
Deceased (Age/cause of death, if known)							

<b>OFFICE USE ONLY</b>
Reviewed/Entered: _____ (Initials)                      (Date)

# Lead Exposure Risk Assessment Questionnaire for Children



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Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Answered by: \_\_\_\_\_

Relationship: \_\_\_\_\_

In addition to New York State’s required testing of all children for lead with a blood lead test at one year of age and again at age two, assessment of risk for lead exposure should be done at each well-child visit or at least annually for each child six months to six years of age.

The questions below serve as a risk assessment tool based on currently accepted public health guidelines. Children found to be at risk for lead exposure should receive a blood lead test whenever such risk is identified.

	YES	NO
<p><b>1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent or ongoing renovation or remodeling?</b> <i>Note: This could include a day care center, preschool, and the home of a babysitter or a relative.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>2. Has your family/child ever lived outside the United States or recently arrived from a foreign country?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>3. Does your child have a brother/sister, housemate/playmate being followed or treated for lead poisoning?</b></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>4. Does your child frequently put things in his/her mouth such as toys, jewelry, or keys? Does your child eat non-food items (pica)?</b> <i>Note: This may include toys or jewelry products that have been recalled by the Consumer Products Safety Commission (CPSC) due to unsafe lead levels: <a href="http://www.nyhealth.gov/environmental/lead/recalls">www.nyhealth.gov/environmental/lead/recalls</a></i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>5. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead?</b> <i>Note: Jobs include house painting, plumbing, renovation, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making or shooting firearms and collecting lead or pewter figurines.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>6. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead?</b> <i>Note: May need to alert parent/caregiver if such an industry is local.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>7. Does your family use products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter?</b> <i>Note: Lead has been found in traditional medicines such as Ayurvedic medicine, liga, greta, azarcon, litargirio, and in cosmetics such as kohl, surma, and sindoor. Lead exposure risk is higher with old, imported, painted, cracked or chipped china, and in low-fired and terra cotta pottery, often made in Latin America and the Middle East.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to any of the above questions is **YES**, then the child is considered to be at risk for lead exposure, and this should be discussed with your provider.