



CHARLES J. SIDLOW, D.P.M.

Medicine and Surgery of the Foot and Leg

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PEDIATRIC INFORMATION SHEET

In order to assist us in making our initial visit as productive as possible, please fill in the following information and bring this with you at the time of your visit.

Child's Name _____ First Visit Date _____

Age _____ Date of Birth _____

Height _____ Weight _____ Shoe Size _____ What is the reason
for this visit (type of foot/leg problem): _____

Has the problem become: Worse _____ Better _____ Same _____

Pediatrician: _____ Date of last visit _____

Referred by: _____

Name of person responsible for account _____

Home Address _____ Phone Number _____

Employer _____ Business phone _____

Insurance Name and ID# _____

Group # _____ Subscriber name and SS# _____

If you have insurance information, please take it to the receptionist for copying at the time of your visit.

Please check, circle or fill in each of the following, where appropriate.

1) Please circle any disease present in the child's immediate family (parent's, siblings, grandparents, uncles or aunts):

Allergy	Asthma	Drug Reactions	Convulsive disease
Hay Fever	Eczema	Bronchitis	Tuberculosis
Sinus	Anemia	Bleeding	Diabetes
Cancer	Leukemia	Epilepsy	

2) Birth History

	Due Date _____	Weight _____	Length _____
Labor:	(1) Onset: Spontaneous _____	Induced _____	
	(2) Length: _____		
	(3) Type: Breach _____	Vertex (head first) _____	
	Cesarean Section _____		
	(4) Type of Anesthesia _____		
	(5) Forceps utilized? _____		

Baby:

Required resuscitation? _____ Oxygen? _____

Incubator? _____

Any problems in the nursery? (circle)

Jaundice

Bleeding

Breathing Difficulties

Rash

Vomiting

Seizures

Blue Spells

Infection

3) Development History:

Indicate age at which child:

Sat without support _____

Crawled _____

Stood with support _____

Walked _____

While walking or running my child is:

Coordinated _____

Always tripping _____

Clumsy _____

Often off balance _____

My child: Likes to walk _____

Likes to run _____

Does not walk for long distances _____

Tires easily _____

Asks to be carried _____

Complains of foot/leg pain or cramping _____

My child's shoes are generally replaced because they become too small

or because they have worn out _____

Previous treatment for foot/leg problems _____

4) Immunizations (yes or no) DPT _____ Oral polio _____ Small pox _____

Tuberculin _____ Measles _____ Mumps _____ Rubella _____

5) Illness (If yes, please explain)

Severe illness _____

Injury _____

Hospitalizations _____

Surgery _____

6) Drug Sensitivities or allergies _____

7) Present medications _____

If you have an infant, please bring a bottle and small toys to amuse your child during the examination. Please bring any worn shoes if the wear pattern is a problem.

Parents' Consent and Medical Authorization for Treatment

I hereby consent to the examination and treatment of my child's foot condition by Dr. Sidlow. I understand that surgery, if needed, will require additional consent.

I hereby grant permission to Dr. Sidlow to secure medical records from any doctor or hospital that my child has/is seeing.

I hereby authorize Dr. Sidlow to release information as needed from my child's records for filing of any insurance benefits. I further authorize payment directly to Dr. Sidlow for benefits due me under my insurance contract, but not to exceed fees charged. Services not covered under my insurance contract are due and payable upon receipt of services or statement unless other arrangements are made in advance.

A copy of this authorization shall be considered as effective and valid as the original unless revoked in writing, and is kept on file with my child's records.

Date _____ Signature _____

(Parent, Guardian, or person authorized to sign.)