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| --- |
| patient’s information |
| Name:  | E-Mail: | Race (optional): |
| Date of birth: | Male or Female | SSN: | Phone: |
| Alternate Phone: | Preferred Pharmacy: | Previous Provider: |
| Mailing Address: | City: | State: | ZIP Code: |
| Physical Address | City: | State: | Zip Code |
| Insurance Name: | ID#:  | Policy Holder: |
| Parent/Legal guardian’s information  |
| Name: | E-Mail: | SSN: |
| Date of birth: | Phone: | Alternate Phone: | Employer: |
| Mailing Address *(if different from patient)*: | City: | State: | ZIP Code: |
| Physical Address *(if different from patient)*: | City: | State: | Zip Code |
| Parent/legal guardian’s Information |
| Name: | E-Mail: | SSN: |
| Date of birth: | Phone: | Alternate Phone: | Employer: |
| Mailing Address*(if different from patient)*: | City: | State: | ZIP Code: |
| Physical Address*(if different from patient)*: | City: | State: | Zip Code |
| Complete list of current prescription and over the counter medications See back [ ]  See attatched [ ]  |
| 1. | Dose: | 2.  | Dose: |
| Does your child have any allergies? (I.E. Medications - Hayfever) See back [ ]  See attatched [ ]  |
| 1. | Reaction: | 2. | Reaction: |
| Background Information |
| Do you choose to vaccinate your child? | **YES** | **NO** | *If yes, please include vaccination record.* | How much did you child weigh at birth? | lbs. | oz. |
| Any maternal complications during pregnancy? | **YES** | **NO** | If yes, explain: |
| Any complications of Labor or Delivery? | **YES** | **NO** | If yes, explain: |
| Did baby go home directly after birth? | **YES** | **NO** | If no, explain: |
| Do any of the following apply to your child? (please write yes or no) See back [ ]  See attatched [ ]  |
| Frequent Ear Infections: | Rheumatic Fever: | Frequent Bronchitis: | Behavior Concerns: |
| Mood Concerns: | Kidney or Bladder Infections: | Meningitis: | Concussion: |
| Seizures: | Chicken Pox: | Surgery (Type) |
| Other: | Has your child ever been in the hospital overnight? | **YES** | **NO** | If yes, explain: |
| Family history (please indicate relationship – i.e. father or mother – OR “n/a”) See back [ ]  See attatched [ ]  |
| Diabetes: | High Blood Pressure: | Heart Disease: |
| Alcoholism: | Stroke: | Mental Illness: |
| Cancer: | Other: |
| **SOCIAL HISTORY** |
| Employer Name:  | Employment Status: Full Time **[ ]** Part Time **[ ]** Self Employed **[ ]**  Not Employed **[ ]**  |
| School: | Grade: | Student Status: Full Time **[ ]** Part Time **[ ]** Not a Student **[ ]**  |
| Signature |
| Signature of Guardian: | Date: |