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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: | | | | | | | | |