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PATIENT INFORMATION

Today's Date _____

Name of Child _____ Sex M F Age _____

Date of Birth _____ Grade in School _____ Nickname _____ Hobbies _____

Home Address _____
 Street _____ City _____ State _____ Zip _____

Ethnicity: (circle one) Hispanic or Latino / Not Hispanic or Latino Language Spoken in Home _____

Race: (circle one) American Indian or Alaskan Native / Asian / Black / Hawaiian or Pacific Islander / White

Email _____ Home Phone _____ Cell Phone _____

FAMILY INFORMATION

Father's / Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone _____ Work Phone _____ (if different from above) Occupation _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Driver's License # _____ State _____ Do you have insurance coverage for child? <input type="checkbox"/> Yes <input type="checkbox"/> No Stepfather's Name _____	Mother's / Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone _____ Work Phone _____ (if different from above) Occupation _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Driver's License # _____ State _____ Do you have insurance coverage for child? <input type="checkbox"/> Yes <input type="checkbox"/> No Stepmother's Name _____
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SIBLING INFORMATION

Name	Age	Date of Birth	Sex

EMERGENCY CONTACT / EMERGENCY TREATMENT

In the event of an emergency, whom should we contact (other than Parents/Guardians)?

Contact #1: _____ Relationship: _____ Phone: _____

Separate Authorization to Treat Form has been **Completed, Signed by Legal Guardian & Notarized:** (Circle One) No Yes Date: _____
 (Allows this emergency contact to bring your child to our office for treatment)

Contact #2: _____ Relationship: _____ Phone: _____

Separate Authorization to Treat Form has been **Completed, Signed by Legal Guardian & Notarized:** (Circle One) No Yes Date: _____
 (Allows this emergency contact to bring your child to our office for treatment)

BIRTH HISTORY

Hospital _____ Obstetrician _____

Type of delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Weight _____

Did baby have any problems at or immediately after birth? _____

List Age _____ Cooed or laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toilet Trained _____

HEALTH HISTORY

Child's Previous Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Is Child under care of other physician's now? _____ YES NO Medications _____

Receiving any medication or drugs? _____ YES NO _____

Has your child been hospitalized? _____ YES NO _____

Date	Reason	Hospital	Allergies _____
_____	_____	_____	Allergies _____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES NO <input type="checkbox"/> <input type="checkbox"/> A.I.D.S./H.I.V. <input type="checkbox"/> <input type="checkbox"/> Allergies / Hay Fever <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Bed Wetting <input type="checkbox"/> <input type="checkbox"/> Birth Defects <input type="checkbox"/> <input type="checkbox"/> Bladder Problems <input type="checkbox"/> <input type="checkbox"/> Bleeding, excessive <input type="checkbox"/> <input type="checkbox"/> Cancer	YES NO <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> <input type="checkbox"/> Chicken Pox <input type="checkbox"/> <input type="checkbox"/> Constipation, Diarrhea <input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Abuse <input type="checkbox"/> <input type="checkbox"/> Ear Infections <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> Hearing Problems	YES NO <input type="checkbox"/> <input type="checkbox"/> Heart Problems <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> <input type="checkbox"/> Lead Poisoning <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Measles <input type="checkbox"/> <input type="checkbox"/> Mononucleosis <input type="checkbox"/> <input type="checkbox"/> Mumps <input type="checkbox"/> <input type="checkbox"/> Pneumonia	YES NO <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Sinus Problems <input type="checkbox"/> <input type="checkbox"/> Speech Problems <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Urinary Diseases <input type="checkbox"/> <input type="checkbox"/> Vision Problems <input type="checkbox"/> <input type="checkbox"/> Worms <input type="checkbox"/> <input type="checkbox"/> Other
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FAMILY HISTORY

Has any member of the family or close relative had:

YES NO <input type="checkbox"/> <input type="checkbox"/> Allergies / Hay Fever <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Alcohol or Chemical Dependency	YES NO <input type="checkbox"/> <input type="checkbox"/> Convulsion or Epilepsy <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Hemophilia - Bleeder <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	YES NO <input type="checkbox"/> <input type="checkbox"/> HIV Infection <input type="checkbox"/> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> <input type="checkbox"/> Migraine <input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorders <input type="checkbox"/> <input type="checkbox"/> Other _____
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RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor child's medical status.

I certify that my minor child is covered by insurance with _____ and assign directly to The Pediatric Specialists Medical Group all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions whether manual or electronic.

I certify that I have been given a copy of The Pediatric Specialists Policy Regarding the Use and Disclosure Confidential Patient Information.

Signature of Parent/Guardian

Date