Patient Information Form:

Please Print and fully complete

Patient Information:
First Name ____________________________Middle Initial ________ Last Name ______________________________
Address _____________________________________City ________________________State ________ZIP ________
DOB ____________________ Sex: ☐ Male ☐ Female Phone#__________________________

Parent or Legal Guardian Information:
First Name ______________________________ Last Name ______________________________ DOB ______________
Address ____City _______________________State ________ZIP ________
Home Phone _____________________Cell Phone ______________________ Work Phone _______________________
E-Mail ___________________________SSN _____________________Relationship to Patient _____________________
Employer ____
Child lives with ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Legal Guardian ☐ Other

Parent or Legal Guardian Information:
First Name ______________________________ Last Name ______________________________ DOB ______________
Address ____City _______________________State ________ZIP________
Home Phone ______________________Cell Phone ______________________Work Phone _______________________
E-Mail ___________________________SSN _____________________Relationship to Patient _____________________
Employer ____

Primary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk
Insurance Name _______________________________ Address ____
Policy Holder ______________________________________DOB _______________Employer ______________________
ID# _____________________Group# _____________________SS# (If needed for billing) ________________________

Secondary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk
Insurance Name _______________________________ Address ____
Policy Holder ______________________________________DOB _______________Employer ______________________
ID# _____________________Group# _____________________SS# (If needed for billing) ________________________

Please list all children in your family who come to this practice:
_____________________DOB _______ ______________________DOB ______ ___________________DOB _____
_____________________DOB _______ ______________________DOB ______ ___________________DOB _____
Preferred E-Mail for the patient portal: ____
Preferred Pharmacy: ______________________ Address _______________________________Phone ____________

Emergency Contact: Name _______________________ Relationship _______________________ Phone ___________

How were you referred to this practice? ☐ Existing patient ☐ Physician Name of patient/physician _____________
☐ Newspaper ☐ Telephone ☐ Internet ☐ Website ☐ Insurance company ☐ Other _____________

I authorize the providers of the practice to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to the practice. If my insurance company rejects or allows only part of the claim for services, I shall be responsible for payment of the balance due and will pay the balance within thirty (30) days.

____
Printed name of patient or parent/guardian Signature Date

Patient Name____Birth Date_______________

Past Medical History

Has our child ever been treated or diagnosed with: (explain)

	Yes	No	
Asthma/wheezing/pneumonia	☐	☐	____________________
Allergies- food/pets/seasonal	☐	☐	____________________
Anemia/blood disorder	☐	☐	____________________
Diabetes	☐	☐	____________________
Ear infections/strep throat	☐	☐	____________________
Genetic disorder	☐	☐	____________________
Heart disease/defects	☐	☐	____________________
Intestinal problems	☐	☐	____________________
Neurological (headaches/seizures)	☐	☐	____________________
Psychological (ADHD, autism, anxiety)	☐	☐	____________________
Urinary tract infections/disorders	☐	☐	____________________
Other chronic conditions	☐	☐	____________________

Has your child ever been hospitalized overnight? ☐ Yes ☐ No Please explain and give dates ______________________

____

Please list any specialist(s) your child is seeing ____

____

Medications

Allergies to medications and reactions ____

Current medications and dose ____

____

Vitamins, herbal supplements, over the counter medications ____

____

Surgical History

Type of surgery and date of surgery ____

Social History

Who lives in the household with your child? ☐ Parent (Mom) ☐ Parent (Dad) ☐ Siblings #_____ ☐ Other ____________

Parent(s) ☐ Married ☐ Single ☐ Divorced ☐ Remarried Name of Step-parent______________________

☐ Custody (Please bring in custody papers if other than shared)

Smokers ☐ Yes ☐ No Pets ☐ Yes ☐ No What Kind? _______________ Age of home___________

Does your child stay home with you? ☐ Yes ☐ No Does your child attend daycare/preschool/babysitter? ☐ Yes ☐ No

Developmental

At what age did your child: roll over _____ crawl _____ walk _____ speak 2 words _____

Present grade in school ___________

Patients Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American

☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Decline to report

Patients Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other __________

Patients Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Decline to report