Patient Registration *(Pediatric)*

Patient Information Date ___/___/___ Chart No. _____

Patient _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Mother/Guardian _____ DoB___/___/___ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Father/Guardian _____ DoB___/___/___ SS# _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Children live with: ☐ Mother ☐ Father ☐ Guardian _____

Emergency Contact Person _____ Relationship _____ Phone _____

Party Responsible for Payment of Medical Services: ☐ Father ☐ Mother ☐ Guardian ☐ Both _____

Who referred you to our office? _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ Relationship _____

Medicaid/Champus/Other _____ Current Card # _____

Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize _____ to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to _____ for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature _____ Relationship _____ Date _____

Witness' signature _____ Date _____

☐ I prefer to do my own insurance filing. Signed _____ Date _____

New Patient Record *(Pediatric)*

Family Information

Date ___/___/___ Chart No. _____

Patient's Name _____ DoB ___/___/___ Sex: ☐ M ☐ F

Mother's Name _____ Age ____ Ph (H) _____ Ph (W) _____

Home Address _____ Mother's Employer _____

Father's Name _____ Age ____ Ph (H) _____ Ph (W) _____

Home Address _____ Father's Employer _____

Referred by _____

Current Medical History

Is your child having any medical problems? ☐ Yes ☐ No

Is he/she taking any medications? ☐ Yes ☐ No

Are immunizations current? ☐ Yes ☐ No

Maternal and Newborn History

Pregnancy *(check problem areas)*

☐ Excessive wt. gain ☐ Urinary infections ☐ Excessive swelling
☐ Rubella ☐ Toxemia ☐ Venereal disease

Alcohol / recreational drugs used during pregnancy? ☐ Yes ☐ No

Birth Delivery: ☐ Vaginal ☐ Caesarean Section _____

Baby was ☐ Full term ☐ Premature ☐ Birth Wt. _____

Was labor difficult or prolonged? ☐ Yes ☐ No _____

Was delivery difficult or complicated? ☐ Yes ☐ No _____

Newborn ☐ Breast ☐ Formula _____

☐ Feeding problems ☐ Colic ☐ Multiple formula changes
☐ Blood in stools ☐ Slow wt. gain ☐ Recurring vomiting
☐ Recurrent diarrhea ☐ Juandice ☐ Other _____

Important Medical Problems or Diagnosis

Drug Allergies

Past Medical and Family History

Has the patient or any family member been hospitalized for a medical or surgical problem? ☐ Yes ☐ No _____

If the patient or any family member has or has had any of the following problems, check the approriate box and list the family member's initial?

P-Patient M-Mother GM-Grandmother
S-Sibling F-Father GF-Grandfather

1. ☐ Trauma: Brokern Bones, loss of consciousness _____
2. ☐ Allergies _____
3. ☐ Drug allergies _____
4. ☐ Asthma _____
5. ☐ Eczema _____
6. ☐ Resp. infect. _____
7. ☐ Ear infections _____
8. ☐ Tuberculosis _____
9. ☐ Immunity prob. / HIV _____
10. ☐ High cholesterol _____
11. ☐ High blood pressure _____
12. ☐ Heart attach / Stroke before age 55 _____
13. ☐ Other heart problems _____
14. ☐ Anemia/Blood disorders _____
15. ☐ Diabetes _____
16. ☐ Obesity _____
17. ☐ Bladder / Kidney _____
18. ☐ Stomach / GI _____
19. ☐ Cancer _____
20. ☐ Seizures _____
21. ☐ Growth _____
22. ☐ Hereditary _____
23. ☐ Learning Problems _____
24. ☐ Attention Deficit / Hyperactivity _____
25. ☐ Emotional/Behavioral _____
26. ☐ Psychiatric _____
27. ☐ Alcohol or Drugs _____

Do you have any other concerns you wish to discuss? ☐ Yes ☐ No

Parent's signature _____ Date _____

Provider's Comments:

Provider's signature _____ Date _____

☐ History Update

Name ______________________ Chart No. [ ]

Date	History Update

Medication

Name ______________________ Sex ☐ M ☐ F DoB ___ /___ /___ Chart No.

Medication and Dosage	Start	Stop	Medication and Dosage	Start	Stop

File: 3430.fdb

Medication

Injection Record

Name ______________________________ Sex ☐ M ☐ F DoB ___ /___ /___ Chart No.

Date	Medication	Lot #	Exp. Date	Dose	Strength	Inj. Site	Adverse Drug Reaction	Dx.	Initials

File: 3430fdb

Injection Record