



## WELCOME TO OUR OFFICE PEDIATRIC FORM

**Personal Information:**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

File #: \_\_\_\_\_

Name: \_\_\_\_\_

Male       Female

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_

SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Name of Parents / Guardians: \_\_\_\_\_

E-mail address: (for monthly newsletter/correspondence only) \_\_\_\_\_

How did you hear about us?  Referral  Mail  Location  Phonebook  Walk-in  Insurance  Other

Who may we thank for referring you to our office? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relation: \_\_\_\_\_

Pediatrician's Name: \_\_\_\_\_ Date of Last Visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for visit: \_\_\_\_\_

**Insurance Information:**

Do you intend to use health insurance?  No  Yes      Are you covered by:  Medicare

**\*\*Please allow our front desk staff to copy your insurance card and drivers' license\*\***

**Account Information:**

Person ultimately responsible for account:  Same as listed above (if different please complete below)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SSN: \_\_\_\_\_ D.L. # \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

(Continued on other side)

**Health History:**

Currently taking any medications?  No  Yes \_\_\_\_\_

List any allergies or anything allergic to: \_\_\_\_\_

List previous surgeries: \_\_\_\_\_

Has your child ever been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)?  No  Yes \_\_\_\_\_

Has your child been vaccinated?  No  Yes \_\_\_\_\_

Number of doses of Antibiotics your child has taken: Past six months \_\_\_\_\_ Lifetime \_\_\_\_\_

Any complications during pregnancy / birth?  No  Yes \_\_\_\_\_

Family History: \_\_\_\_\_

**Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:**

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Irritability | <input type="checkbox"/> Digestive Problems    | <input type="checkbox"/> Scoliosis     |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Difficulty sleeping   | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> ADHD         | <input type="checkbox"/> Bed Wetting           | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Depression   | <input type="checkbox"/> Stomach/bowel problem | <input type="checkbox"/> Colic         |
| <input type="checkbox"/> Fevers         | <input type="checkbox"/> Other _____  |  |  |

List any other serious medical condition(s): \_\_\_\_\_

**Payment Information:**

**PLEASE NOTE:** On your first visit, payment is due in full at the time of service, unless prior arrangements were made. We **DO** accept insurance assignment, but **NOT** until we are able to contact your insurance carrier directly to verify benefits. Payment you make today which is verified to be covered by insurance will be credited to your account, or reimbursed upon your request.

**Based on this, payment today will be:** \_\_\_\_\_ **Cash** \_\_\_\_\_ **Check** \_\_\_\_\_ **Credit Card (Visa, MC)**

**I authorize** the doctor to evaluate and care for my son / daughter as he / she deems appropriate. I understand and agree that all services rendered my child at this office are my financial responsibility and are charged directly to me. Even if submitted to insurance, ultimately I am personally responsible for payment.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_