



Confidential Patient (Child) Information

Date _____

Child's Information

Child's Full Name _____ Nickname _____
Sex: F ___ M ___ Birth date: ___/___/___ Age ___ Grade ___ Social Security No. _____
Home Address _____ Zip _____
Home Phone # _____ School _____
Parent/Guardian Name _____ Address _____
Reason for Visit _____
Additional Concerns? _____

Family Information (Parents and/or Guardians)

Mother's Name _____ Cell Phone _____ Work Phone _____
Employer/Occupation _____
Father's Name _____ Cell Phone _____ Work Phone _____
Employer/Occupation _____

Emergency Contact (other than Parents/Guardians)

Name: _____ Relation to child: _____
Home phone: _____ Cell phone: _____ Work phone: _____

Birth Information

Delivery:
Natural ___ Cesarean ___ Forceps ___ Vacuum ___
Length of Labor _____ Weeks Gestation _____
Number of Days in Hospital _____
Problems during Pregnancy? Yes ___ No ___
If yes, explain _____
Pain Medication during Labor? Yes ___ No ___
Problems after birth? Yes ___ No ___
If yes, explain _____
Birth weight ___ Length ___ Blood type ___
Breast fed? Yes ___ No ___ How long? _____
Formula fed? Yes ___ No ___ How long? _____
Birth order? _____

Development

Please list the ages of the following events:
Sat alone _____ Stood alone _____ Walked alone _____
First words _____ First tooth _____ Toilet trained _____

Habits

Does your child sleep through the night? Yes ___ No ___
Is your child happy? ___ Fussy? ___ When? _____
What are some favorite foods? _____

Vaccinations

Please list the dates if your child has received these immunization/vaccinations:
Hepatitis ___/___ Hib ___/___ DPT ___/___ MMR ___/___ Chicken Pox ___/___

Medical History

List any allergies your child has: _____
List any prescriptions/over the counter medications, vitamins or herbs your child is taking: _____
List previous surgeries/treatments, injuries, or broken bones with dates: _____

Please list dates of when your child has had any of the following illnesses:

Measles ___/___ Mumps ___/___ German Measles ___/___ Rheumatic Fever ___/___
Chicken Pox ___/___ HIV/AIDS ___/___ Cancer ___/___ Pneumonia ___/___ Tuberculosis ___/___
Asthma ___/___ Urinary Tract Infection ___/___ Diabetes ___/___ Ear Infections ___/___

Other Illnesses/Accidents? _____
Number of antibiotics your child has been on: _____

Insurance Information

Primary Insurance Company

Company name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Member ID#: _____ Group #: _____
Insured's Name: _____ Birth date: __/__/__ Relation: _____
Insured's S.S.#: _____ Insured's Employer: _____

Secondary Insurance Company

Company name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Member ID#: _____ Group #: _____
Insured's Name: _____ Birth date: __/__/__ Relation: _____
Insured's S.S.#: _____ Insured's Employer: _____

Account Information

Person Ultimately Responsible for Account

Name: _____ Relation: _____
Billing Address: _____
Home phone #: _____ Employer: _____ Work phone #: _____
SS#: _____

Desired Method of Payment

Cash _____ Insurance _____

Financial Difficulty? Please let us know-- we can work with you on payment options and plans!

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider, parent, and patient.

Our office policy requires payment in full for all services rendered at the time of visit unless other arrangements are made. The person bringing the patient to this office is responsible for the charges unless other arrangements have been made. If the account is not paid within 90 days of the date of service, and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account.

I hereby authorize payment of benefits due me for services rendered directly to the provider of benefits. I further authorize the physician and/or supplier to release any information required to process an insurance claim.

I understand the above information, guarantee this form is completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Responsible Person: _____ Date: _____