CARING PEDIATICS

NEW PATIENT INFORMATION SHEET

Patient's Last Name:________________ First :________________ MI: ______

Birthdate________________ Soc.Sec.Number________________ Male Female______

Mailing Address________________ City/State/Zip________________

Home Phone (____)________________ Cell Phone(____)________________ E-mail________________

IF PATIENT IS A CHILD OR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

Responsible Party's Name:________________ Relation To Patient________________

Mailing Address________________ City/State/Zip________________

Home Phone (____)________________ Work Phone(____)________________ Cell Phone(____)________________

Birthdate________________ Soc.Sec.Number________________ Male___ Female___

E-mail________________ Marital Status: M S D W Employed by:________________

Employer's Address________________ City/State/Zip________________

Ethnicity (optional) ________________ Language spoken (if other than English): ________

Preferred method of learning: handout verbal explanation video other________

EMERGENCY CONTACT (Someone who does not live with you):

Name________________ Relationship________________

Address________________ City/State/Zip________________

Home Phone(____)________________ Work Phone(____)________________ Cell Phone(____)________________

PHARMACEUTICAL INFORMATION:

Pharmacy Name________________

Address________________ City/State/Zip________________

Phone (______) ________________ Fax (_____) ________________

HEALTH HISTORY

Please complete this form carefully and thoroughly. If there are any questions you do not understand, please ask a staff member or physician for assistance. If you would like to inform the doctor or any additional information, please make sure to note the information on this form.

Please list any siblings name and age including father and mother:

____

________________ ________________

________________ ________________

PATIENT MEDICAL HISTORY

	Y	N
Has child been hospitalized for anything since birth? If yes, please explain.	Y	N
Has child had any surgeries or operations? If yes, please explain.	Y	N
Is your child on any medications today? If yes, please list medications and how long child has been on them.	Y	N
Does your child take medication regularly? If yes, please list medications and how long child has been on them.	Y	N
Has child had allergic reaction to any immunization? If yes, please list each immunization and what the reaction was.	Y	N
Any History of Chicken Pox disease? If yes, indicate date?	Y	N

FAMILY HISTORY

	Y	N
Are the child's parents both in good health? If no, please list each health concern and which parent it applies to.	Y	N

Has the child or any family member had any of the following illnesses?	Child		Family		If yes, please indicate who.
Anemia	Y	N	Y	N	
Asthma	Y	N	Y	N	
Allergies	Y	N	Y	N	
Diabetes	Y	N	Y	N	
Heart Trouble/ Murmur	Y	N	Y	N	
Tuberculosis	Y	N	Y	N	
Mental Illness	Y	N	Y	N	
Drug Problem	Y	N	Y	N	
Alcohol Problem	Y	N	Y	N	
Inherited Illness ex, sickle cell, fragile x syndrome, Cystic fibrosis.	Y	N	Y	N	
Cancer	Y	N	Y	N	
Eye Problems	Y	N	Y	N	
Frequent Ear Infections	Y	N	Y	N	
Problems with Urination	Y	N	Y	N	
Problems with Diarrhea or Constipation	Y	N	Y	N	
Seizures	Y	N	Y	N	
AIDS	Y	N	Y	N	
Other	Y	N	Y	N	

Please add any additional information you wish to provide about child's family History.

SAFETY ENVIRONMENT

Please circle your residence: private home apartment mobile home other

	Y	N
Is the hottest temperature of the water in your home less than130 degrees?	Y	N
Is there a working smoke alarm on each floor in the house?	Y	N
Does your child always use a car seat or seat belt when riding in a car?	Y	N
Are there any smokers in the household?	Y	N
Are there any problems with the condition of your home? (Insects, rats, peeling paint, etc.)	Y	N
Are there any pets in the house?	Y	N
Are there any guns in the house? Locked?	Y	N
Does your child wear a helmet when riding a bike/motor Scooter/skateboard?	Y	N

I HEREBY AUTHORIZE THE PROVIDING PHYSICIAN TO RELEASE AND OBTAIN ANY INFO REQUIRED IN THE COURSE OF EXAMINATION OR TREATMENT/ INSURANCE.

SIGNATURE______________________________ DATE:________________