

## Patient and Family Information

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  Male  Female

Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Responsible Party \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Name of Mother/Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Name of Father/Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

## Child's Health History

Former Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of last doctor visit \_\_\_\_\_

Child's Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight at Birth \_\_\_\_\_

Does your child take vitamins, fluoride, iron or other supplements?  Yes  No

Please list any medications your child is currently taking: \_\_\_\_\_

Please check all that apply to your child:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergies: _____        | <input type="checkbox"/> Diarrhea or Constipation | <input type="checkbox"/> High Cholesterol         |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Discipline Problems      | <input type="checkbox"/> Kidney/Bladder Problems  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Ear Infections           | <input type="checkbox"/> Latex Sensitivity        |
| <input type="checkbox"/> Bed Wetting             | <input type="checkbox"/> Eating Problems          | <input type="checkbox"/> Mumps, Measles           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Eczema/Skin Problems     | <input type="checkbox"/> Pneumonia                |
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Eye Problems             | <input type="checkbox"/> Sleeping Problems        |
| <input type="checkbox"/> Convulsions/Epilepsy    | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Speech Problems          |
| <input type="checkbox"/> Croup                   | <input type="checkbox"/> Handicaps/Disabilities   | <input type="checkbox"/> TB/Lung Disease          |
| <input type="checkbox"/> Dental Problems         | <input type="checkbox"/> Hearing Problems         | <input type="checkbox"/> Temper Problems          |
| <input type="checkbox"/> Developmental Problems  | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Thumb Sucking            |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Toilet Training Problems |
|  | <input type="checkbox"/> Hepatitis - Type _____   | <input type="checkbox"/> Tonsillitis              |
|  | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Tuberculosis             |
|  |   | <input type="checkbox"/> Other _____              |

Please describe any special medical problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





### Primary Health Insurance

Person Responsible for Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group# \_\_\_\_\_



### Additional Insurance

Person Responsible for Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group# \_\_\_\_\_

### Assignment and Release

I hereby authorize payment directly to \_\_\_\_\_  
 for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially  
 responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf  
 or my dependents

I authorize the above doctor and /or any provider or supplier of services in this office to release the  
 information requires to secure the payment of benefits. I authorize the use of this signature on all  
 insurance submissions.

Signature of Responsible party \_\_\_\_\_ Date \_\_\_\_\_

