THE PEDIATRIC SPECIALISTS Medical Group

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PATIENT INFORMATION

Today's Date_____

Name of Child_____ Sex ☐ M ☐ F Age _____

Date of Birth _____ Grade in School _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Ethnicity: (circle one) Hispanic or Latino / Not Hispanic or Latino Language Spoken in Home _____

Race: (circle one) American Indian or Alaskan Native / Asian / Black / Hawaiian or Pacific Islander / White

Email _____ Home Phone _____ Cell Phone _____

Referred by _____

FAMILY INFORMATION

Father's / Guardian's Name_____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone _____
(if different from above)

Occupation _____

Employer _____

Soc. Sec. #_____ Birthdate _____

Driver's License # _____ State_____

Do you have insurance coverage for child? ☐ Yes ☐ No

Stepfather's Name_____

Mother's / Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone_____
(if different from above)

Occupation _____

Employer_____

Soc. Sec. #_____ Birthdate_____

Driver's License # _____ State_____

Do you have insurance coverage for child? ☐ Yes ☐ No

Stepmother's Name _____

SIBLING INFORMATION

Name	Age	Date of Birth	Sex

EMERGENCY CONTACT / EMERGENCY TREATMENT

In the event of an emergency, whom should we contact (other than Parents/Guardians)?

Contact #1: _____ Relationship: _____ Phone: _____

Separate Authorization to Treat Form has been **Completed, Signed by Legal Guardian & Notarized**: (Circle One) No Yes Date:_____
(Allows this emergency contact to bring your child to our office for treatment)

Contact #2: _____ Relationship: _____ Phone: _____

Separate Authorization to Treat Form has been **Completed, Signed by Legal Guardian & Notarized:** (Circle One) No Yes Date:_____
(Allows this emergency contact to bring your child to our office for treatment)

BIRTH HISTORY

Hospital _____ Obstetrician _____

Type of delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Weight _____

Did baby have any problems at or immediately after birth? _____

List Age Cooed or laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toilet Trained _____

HEALTH HISTORY

Child's Previous Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO	
Is Child under care of other physician's now? _____	☐	☐	Medications _____
Receiving any medication or drugs? _____	☐	☐	_____
Has your child been hospitalized? _____	☐	☐	_____

Date Reason Hospital Allergies _____

_____ Allergies _____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Cerebral Palsy	☐	☐	Heart Problems	☐	☐	Rheumatic Fever
☐	☐	Allergies / Hay Fever	☐	☐	Chicken Pox	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	Constipation, Diarrhea	☐	☐	Kidney Disease	☐	☐	Speech Problems
☐	☐	Asthma	☐	☐	Convulsions / Epilepsy	☐	☐	Lead Poisoning	☐	☐	Thyroid Disease
☐	☐	Bed Wetting	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Measles	☐	☐	Urinary Diseases
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Bleeding, excessive	☐	☐	Fainting	☐	☐	Mumps	☐	☐	Worms
☐	☐	Cancer	☐	☐	Hearing Problems	☐	☐	Pneumonia	☐	☐	Other

FAMILY HISTORY

Has any member of the family or close relative had:

YES	NO		YES	NO		YES	NO	
☐	☐	Allergies / Hay Fever	☐	☐	Convulsion or Epilepsy	☐	☐	HIV Infection
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Hemophilia - Bleeder	☐	☐	Psychiatric Disorders
☐	☐	Alcohol or Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Other _____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor child's medical status.

I certify that my minor child is covered by insurance with _____ and assign directly to The Pediatric Specialists Medical Group all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions whether manual or electronic.

I certify that I have been given a copy of The Pediatric Specialists Policy Regarding the Use and Disclosure Confidential Patient Information.

_____ _____

Signature of Parent/Guardian Date