Patient Registration

Patient Information

First name: ______________________ Middle: ______________________ Last: ____________________________

Nickname/Preferred name: ____

Gender: ( ) Male ( ) Female Date of birth (MM/DD/YYYY): _______/_______/_______

Responsible Party

Name: ____________________________________ Relationship to patient: ______________________________

Gender: ( ) Male ( ) Female Date of birth (MM/DD/YYYY): _______/_______/_______

Address: ____

____

City: ____________________________________ State: ________ Zip: ____________________

Mobile Phone: ______________________________ Home Phone: ______________________________

Email address: ____

Preferred contact method: ( ) Home phone ( ) Mobile phone ( ) Text ( ) Email

How did you find out about us? ____

Insurance Information

Primary Insurance:

Name of insurance holder: ____

Date of birth (MM/DD/YYYY): ______/______/______ Relationship to patient: ______________________________

Employer: ______________________________ Insurance Company: ______________________________

Insured Social Security Number: ______________________ Member ID: ______________________

Group Number: ______________________________ Insurance Phone: ______________________________

Insurance Mailing Address: ____

Secondary Insurance: (if applicable)

Name of insurance holder: ____

Date of birth (MM/DD/YYYY): ______/______/______ Relationship to patient: ______________________________

Employer: ______________________________ Insurance Company: ______________________________

Insured Social Security Number: ______________________ Member ID: ______________________

Group Number: ______________________________ Insurance Phone: ______________________________

Insurance Mailing Address: ____

Medical History

Child's Full Name: ______________________ **Nickname:** ____________

Date of birth: / / **Gender:** ( ) M ( ) F **Race/Ethnicity:** ____________

Height: ________ **Weight:** ________ **Date of last physical examination:** ____________

Name/address/phone of primary physician:

____

Name/address/phone of medical specialists:

____

____

Is your child being treated by a physician at this time? .... ( ) YES ( ) NO
Reason ____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?.........( ) YES ( ) NO

List name, dose, frequency & date started (list on reverse if necessary):

____

____

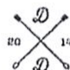
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?
( ) YES ( ) NO List date & describe: ____

____

Has your child ever had a reaction to or problem with an anesthetic? Describe ....( ) YES ( ) NO
Describe ____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? .... ( ) YES ( ) NO

List & describe: ____



Is your child allergic to latex or anything else such as metals, acrylic, or dye? .... ( ) YES ( ) NO

List & describe: ______________________________

Is your child up to date on immunizations against childhood diseases?........ ( ) YES ( ) NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions .... ( ) YES ( ) NO

Problems with physical growth or development .... ( ) YES ( ) NO

Sinusitis, chronic adenoid/tonsil infections .... ( ) YES ( ) NO

Sleep apnea/snoring, mouth breathing, or excessive gagging .... ( ) YES ( ) NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease .... ( ) YES ( ) NO

Irregular heart beat or high blood pressure .... ( ) YES ( ) NO

Asthma, reactive airway disease, wheezing, or breathing problems .... ( ) YES ( ) NO

Cystic fibrosis .... ( ) YES ( ) NO

Frequent colds or coughs, or pneumonia .... ( ) YES ( ) NO

Frequent exposure to tobacco smoke .... ( ) YES ( ) NO

Jaundice, hepatitis, or liver problems .... ( ) YES ( ) NO

Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems .... ( ) YES ( ) NO

Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions .... ( ) YES ( ) NO

Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder .... ( ) YES ( ) NO

Bladder or kidney problems .... ( ) YES ( ) NO

Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems .... ( ) YES ( ) NO