Patient Information: Primary Language: _____

First Name: _____Last Name: _____MI:_____DOB:_____

Home Phone: _____Cell:_____SSN#:_____

Home address: _____

City: _____State:_____Zip:_____

Email: _____

School:_____

Family Information

PARENTS: Single Married Divorced Separated Widowed

Mothers Name: _____ Fathers Name _____

Guardian/Caretakers Name and Phone #, if applicable_____

Siblings living in the home _____

Pediatrician

Name of Pediatrician(s) _____ , _____

Dates of care: From _____ to _____ , _____ to _____

Health Insurance

Name of Insured: _____DOB:_____SSN#:_____

Primary Insurance: _____

Policy/ID#:_____GRP#:_____

Secondary Insurance: _____

Policy/ID#:_____GRP#:_____

Emergency Contact:

First Name: _____Last Name: _____Phone:_____

First Name: _____Last Name: _____Phone:_____

Medications

Are you presently taking any topical/oral/injectable medications? **YES** **No**

If yes please list medication, dosage, and how many times a day.

Preferred Pharmacy:

Pharmacy: _____City:_____

Do you have allergies? **YES** **NO**

If so, please list: _____

Surgeries/Hospitalizations: Have you had any surgeries or hospitalizations in your lifetime? If so please list:

SURGERY/HOSPITALIZATION/PROCEDURE	WHEN?

Medical History:

- Anemia/low iron count
- Arthritis/joint problems
- Asthma/breathing issues
- HIV/blood disorders
- Blood transfusion
- Cancer
- Cardiac pacemaker
- Diabetes
- Epilepsy/seizures
- Glaucoma
- Heart murmur/arrhythmias
- Heart attack
- Hepatitis
- High blood pressure
- Jaundice
- Kidney problems
- Psychiatric/depression
- Rheumatic fever
- Std
- Sinus/snoring
- Stroke
- Tuberculosis
- Ulcers/heartburn

Do you consume Alcohol? YES NO How many drinks per week_____

Do you smoke? YES NO How many packs per day_____ For how many years?_____Quit? YES NO

Do you consume illicit drugs? YES NO

Any other serious illness or concerns _____

_____

_____

Signature of Responsible Party:_____Date:_____