COMPLETE BOTH PAGES
BLACK INK ONLY

Checked-in: _________ *Updated*: __________

Patient Name: ____ Sex: M / F
(First) (MI) (Last)

Address: ____
(Street) (City) (State) (Zip)

Age: ____ D/O/B: ____________________ Social Security #: _______________________

Guarantor Information (person financially responsible for patient):

Name: ____ D/O/B: _________________

Address: ____

Social Security #: _________________ Relationship to Patient: _________ Marital Status: __

PHONE: Home: ________________ Work: ________________ Cell: __________________

Employer: ____

Employer Address: ____

Insured's Name (if different than above): ___________________________ D/O/B:________

Relationship to Patient: ________________________ Social Security #: ________________

Insured's Employer: ______________________________________ Phone #: ___________

Emergency Contact (person not living with you we may contact in case of emergency):

Name: ____ Relationship: _________________

Phone #s: ____

Referring Physician: ____

Family Physician: ____

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Adult & Pediatric SPECIALISTS

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Alternate Parent Information:

Name: ____ D/O/B: ____________

Address: _______________________________ Social Security #: ____________

PHONE: Home: ______________ Work: ______________ Cell: ______________

Employer: ______________ Employer Address: ___________________________

____

Insurance:

Primary Insurance: _________________ Policy Holder: ______________________

Policy #: ________________________ Group #: _________________________

Secondary Insurance: _________________ Policy Holder: ____________________

Policy #: ________________________ Group #: _________________________

____

Auto Insurance (if due to an accident):

Policy Holder: _________________________ Claim #: _____________________

Company: _____________________________ Phone #: ____________________

Address: ____

Date of Accident:______________ Person handling claim: _____________________

____

Do you have an attorney or legal action current or pending for the condition for which you are seeking legal consultation?

If yes - Name of Attorney: ____

Address: ______________________________________ Phone #: ___________

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Checked-in: _________ *Updated*: __________

Patient Name: ________________________________ D/O/B: ___________

Height: ____________ Weight: ____________ Birth Weight: ___________

Reason for today's visit:____

Complications with pregnancy:

Was the baby born prematurely? No Yes If yes, how early?___________

Did the baby stay in the intensive care? No Yes If yes, How long? __________

Was the baby on a ventilator No Yes If yes, how long? ___________

Did the baby have any bleeding in the brain? No Yes

Any birth trauma: Skull Fracture / Cephalohematoma / Brachioplexus Nerve Injury

At what age did your child start walking? ___________________

At what age was your child "potty" trained: ___________________

Does your child have any of the following?

Hydrocephalus? No Yes Lung Problems

Genetic disorders/syndromes? *Please list*: ______________________________________

Please list any other ***chronic health problems*** of your child? ______________________________

____

Please list any ***other specialists*** who care for your child: _________________________________

____

Past Surgeries &/or Hospitalizations	Date	Complications

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Adult & Pediatric SPECIALISTS

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Patient Name: ____

Current Medications:

Name of Medication	Dose	Times given

Medication or other ALLERGIES ____

____

Allergy to Latex: **No** **Yes**

Diet: ___ Normal for age ___ by mouth ___ by tube

Family History: *Please circle those conditions present in siblings, parents and grandparents*

Heart Disease	Cancer	Diabetes	High Blood Pressure
Liver Disease	Birth Defects	Kidney Disease	Bleeding Problems

If yes, explain ____

Have you been told your child has any delays in developing skills? No Yes

Motor **Speech/Language** **Social**

If yes, explain____

____

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Adult & Pediatric

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Patient Name: ____

Review of Systems: (conditions or symptoms your child has currently OR had in the past)

Constitutional

Unexplained fever **(recent)**	Yes	No
Weight loss	Yes	No

Eyes

Eyes crossing	Yes	No
Vision loss	Yes	No

Ear, Nose, Throat and Mouth

Hearing loss	Yes	No
Trouble swallowing or chewing ***(circle one or both)***	Yes	No
Choking	Yes	No
Neck pain	Yes	No

Respiratory

Turning blue	Yes	No
Mechanical ventilation – history of / currently use	Yes	No
Tracheostomy – history of / currently use	Yes	No
BPD	Yes	No

Cardiovascular

Heart abnormality or defect	Yes	No

Endocrine

Growth problems	Yes	No
Excessive thirst or urination	Yes	No

Integumentary

Birthmarks	Yes	No
Sacral or other spinal dimple	Yes	No

Gastrointestinal

Constipation	Yes	No
Bowel incontinence	Yes	No

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Musculoskeletal

Back pain	Yes	No
Arm pain	Yes	No
Arm numbness	Yes	No
Leg pain	Yes	No
Leg numbness	Yes	No
Scoliosis	Yes	No

Genitourinary

Kidney or urinary infections	Yes	No
Bladder reflux	Yes	No
Urinary incontinence	Yes	No
Urethral straight catheterization (non-balloon)	Yes	No

Neurological

Headaches	Yes	No
Dizziness	Yes	No
Seizures	Yes	No

Hematologic/Lymphatic

Bleeding tendencies/Hemophilia/Clotting disorder	Yes	No
Anemia	Yes	No

Social Development

Problems in school	Yes	No
Needs special help in school	Yes	No
Performs at or above grade level	Yes	No

Form completed by: ______________________ **Date:** __________

Relationship to child: ______________________________