PATIENT MEDICAL INFORMATION **DATE FORM COMPLETED:_____**

NAME:_____ BIRTHDATE:_____SEX: M F

EMERGENCY CONTACT OTHER THAN PARENT:_____

RELATIONSHIP:_____ CONTACT PHONE NUMBER:_____

CHRONIC/RECURRENT MEDICAL PROBLEMS_____

_____

CURRENT MEDICATIONS:_____

NEWBORN INFORMATION

FULL-TERM/PRE-TERM VAGINAL OR C-SECTION BIRTHWEIGHT :_____
CIRCLE ONE CIRCLE ONE

HOSPITAL_____ BREAST OR BOTTLE FED:_____

PREGNANCY/DELIVERY/NEONATAL COMPLICATIONS:_____

_____

OTHER PERSONS IN HOME (USE BACK IF NECESSARY)

NAME RELATIONSHIP AGE HEALTH

_____

_____

_____

FAMILY MEDICAL HISTORY (PLEASE SPECIFY FAMLY MEMBER RELATIONSHIP MATERNAL/PATERNAL PARENT OR GRANDPARENT/SIBLING)

ALLERGIES/ASTHMA _____

DIABETES_____

HEART/VASCULAR DISEASE_____

TUBERCULOSIS_____

KIDNEY DISEASE_____

URINARY TRACT INFECTIONS_____

CANCER_____

SEIZURE_____

PSYCHIATRIC DISORDER_____

VISION AND OR HEARING PROBLEMS_____

MIGRAINES_____

HYPERACTIVITY OR LEARNING DISABILITY_____

Who would you like to be your new primary care physician?_____

PATIENT INFORMATION (LIST ALL CHILDREN WHO ARE PATIENTS WHO HAVE THE SAME RESPONIBLE PARTY AND INSURANCE)

NAME:_____ BIRTHDATE:_____SEX: M F

NAME:_____ BIRTHDATE:_____SEX: M F

NAME:_____ BIRTHDATE:_____SEX: M F

NAME:_____ BIRTHDATE:_____SEX: M F

NAME:_____ BIRTHDATE:_____SEX: M F

NAME:_____ BIRTHDATE:_____SEX: M F

ADDRESS:_____CONTACT PHONE: _____

_____OTHER PHONE:_____
CITY STATE ZIP

RESPONSIBLE PARTY INFORMATION

NAME:_____ BIRTHDATE:_____ SEX: M F

ADDRESS:_____RELATIONSHIP : _____

_____ PHONE:_____
CITY STATE ZIP

INSURANCE INFORMATION

SUBSCRIBER NAME:_____ BIRTHDATE:_____ SEX M F

INSURANCE :_____ COPAY:_____ DEDUCTIBLE AMOUNT:_____

ADDRESS:_____ _____
STREET OR PO BOX CITY ZIP

POLICY #_____GROUP #_____

PARENT/GUARDIAN INFORMATION

NAME:_____ OCCUPATION:_____
MOTHER'S NAME MARRIED/DIVORCED/ WIDOWED

NAME:_____OCCUPATION:_____
FATHER'S NAME MARRIED/DIVORCED/ WIDOWED

I have read and understand the ( ) HIPAA Policy and the ( ) Financial Policy Date :_____