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PATIENT INFORMATION

Patient name: ____
Address: ______________________ Nickname of child: ____________
City: ______________________ State: _____ Zip: ___________
Phone #: ______________________ Social Security #: ______________
Sex: (M/F) _____________________ Date of Birth: ________________
Father/ Guardian name: _____________ Mother/Guardian name: __________
Father's Cell Phone #: _____________ Mother's Cell Phone #:___________
Child lives with: ____

INSURANCE INFORMATION

Primary Insurance Company: ________________________________
Insurance Address: _______________________________________
City: __________________ State: _______ Zip: ______________
Insured name (Policyholder): _______________________________
Address: ____
City: __________________ State: _______ Zip: ______________
Social Security #: ___________ DOB: _______ Sex: ___ Marital Status______
Relationship to patient: ________________ Policy or group #: ___________
Identification #: _____________ Policy type: Employer__ Group __ Non-Group__
Employer name: _____________ Employer Address: _________________
Employer City: _____________ State: _______ Zip: _______________
Work Phone#: ____

Secondary Insurance Company (if applicable): ____________________
Address: ____
City: ___________________ State: _______ Zip: ______________
Insured name: ____
Address: ____
City: ___________________ State: _______ Zip: ______________
Social Security #: _____________ DOB: _______ Sex: ___ Marital Status: _____
Relationship to the Patient: ______________ Policy or Group #: ___________
Identification #: ____
Policy Type: EMP __ Group __ Non-Group__ Medigap __ Medicaid __ Supplement___
Employer name: ____
Employer Address: ____
Employer City: _____________ State: _______ Zip: _______________
Work Phone #: ____
Please include any additional insurance information on the back of this sheet.

I authorize the release of any information necessary to process my insurance claims. I assign and request payment directly to Forest Pediatrics. I understand that I am responsible for any amount not covered by insurance.
Signature: ______________________________ Date: _______________

PEDIATRIC HISTORY

Pregnancy complications:	Yes	No
Premature delivery	___	___
High Blood Pressure	___	___
Toxemia	___	___
Medications: (if yes, list)	___	___

____

____

Bleeding (if yes, what month)	___	___
Serious illnesses	___	___
Infections	___	___
Previous miscarriages	___	___
C-Section (if yes, why)	___	___

____

Birth History:

Place of Birth: _________________

Birth Weight: __________________

Length: ______ Hours in labor: ___

Adopted? (Y/N) _________________

Problems at Birth	Yes	No
Jaundice	___	___
Breathing problems	___	___
Antibiotics	___	___
Cord around neck	___	___

Other problems (explain):_________

____

Breast :______ Formula: _________

Development: At what age did your child:

Smile: _____________ Roll over: ___________ Sit alone: ____________

First tooth: ________ Walk Alone: __________ Use 1st word with meaning: _________ Use 3 word sentences: _______ Bladder trained: _________ Bowel trained: __________

Ride tricycle: _____________ Tie Shoes: _____________

Hospitalizations and operations:	Date
1)____________________________	______
2)____________________________	______
3)____________________________	______
4)____________________________	______
5)____________________________	______

Serious or Chronic Illness?

____

____

____

____

____

Child's Illness	Yes	No	Date
Chicken Pox	___	___	______
Meningitis	___	___	______
Pneumonia	___	___	______
Diabetes	___	___	______
Seizures	___	___	______
Sickle cell	___	___	______
Allergies	___	___	______
Asthma	___	___	______
Whooping cough	___	___	______
Measles	___	___	______
Mumps	___	___	______
Urinary tract infections	___	___	______
Congenital heart disease	___	___	______

Medications child takes routinely

____

____

____

____

____

School problems? (Y/N) _________

Describe______________________

Allergies to Medications:

____

____

____

Form reviewed by: _____________ MD/NP

Pt. name & DOB_________________

Social History:

Child's family	Age	Present Health or Cause of Death
Mother	___	_______________
Father	___	_______________
Siblings' names		
______________	___	_______________
______________	___	_______________
______________	___	_______________
______________	___	_______________
______________	___	_______________
______________		_______________

Smokers in household (Y/N) ______

Pets: (list)________________________

____

Child lives with?_________________

____

Any social issues we should be aware of?________________________

____

____

____

____

Family Medical History:	Mother's side	Father's side
Diabetes	____________	____________
Heart problems	____________	____________
High blood pressure	____________	____________
Stroke	____________	____________
Cancer	____________	____________
Tuberculosis	____________	____________
Ulcer	____________	____________
Arthritis	____________	____________
Obesity	____________	____________
Depression	____________	____________
Suicide	____________	____________
Other mental illness	____________	____________
Thyroid problems	____________	____________
Sickle Cell		____________
Seizures	____________	____________
Bed wetting	____________	____________
Allergies	____________	____________
Asthma	____________	____________
Food Allergies	____________	____________
Sinus problems	____________	____________
Growth delay	____________	____________
Genetic disorders	____________	____________

Is there anything else we should know in order to better care for your child?

____

____

Reviewed by __________________ MD/NP Name & DOB _________________________