NEW PATIENT REGISTRATION FORM

CHILD'S INFORMATION – SEPARATE FORMS MUST BE COMPLETED FOR EACH CHILD IN A FAMILY

CHILD'S FULL NAME (LAST, MIDDLE, FIRST)			CHILD'S GENDER ☐ MALE ☐ FEMALE	CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER ________	CHILD'S DATE OF BIRTH
PRIMARY HOME ADDRESS			FAMILY'S PRIMARY EMAIL ADDRESS		
CITY	STATE	ZIP	CHILD'S ETHNICITY ☐ DECLINE ☐ NON-HISPANIC ☐ HISPANIC		CHILD'S RACE ☐ DECLINE ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIN OR PACIFIC ISLANDER ☐ WHITE ☐ OTHER ________
PRIMARY HOME PHONE	PRIMARY CELL PHONE		PRIMARY WORK PHONE		

MOTHER or LEGAL GUARDIAN'S INFORMATION / FATHER or OTHER LEGAL GUARDIAN'S INFORMATION

MOTHER/GUARDIAN'S FULL NAME			FATHER/GUARDIAN'S FULL NAME		
MOTHER/GUARDIAN'S SOCIAL SECURITY #	MOTHER'S MAIDEN NAME OR GUARDIAN'S RELATION TO THE PATIENT *(IF APPLICABLE)*		FATHER/GUARDIAN'S SOCIAL SECURITY #	CHILD LIVES WITH *(CHECK ONE)* ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER ________	
MOTHER/GUARDIAN'S DATE OF BIRTH	MOTHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED		FATHER/GUARDIAN'S DATE OF BIRTH	FATHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED	
MOTHER/GUARDIAN'S MAILING ADDRESS ☐ *(CHECK IF SAME AS CHILD)*			FATHER/GUARDIAN'S MAILING ADDRESS ☐ *(CHECK IF SAME AS CHILD)*		
CITY	STATE	ZIP	CITY	STATE	ZIP
MOTHER/GUARDIAN'S HOME PHONE	MOTHER/GUARDIAN'S CELL PHONE		FATHER/GUARDIAN'S HOME PHONE	FATHER/GUARDIAN'S CELL PHONE	
MOTHER/GUARDIAN'S EMPLOYER	MOTHER/GUARDIAN'S WORK PHONE		FATHER/GUARDIAN'S EMPLOYER	FATHER/GUARDIAN'S WORK PHONE	
MOTHER/GUARDIAN'S EMAIL ADDRESS			FATHER/GUARDIAN'S EMAIL ADDRESS		

INSURANCE INFORMATION – PLEASE PROVIDE A COPY OF THE INSURANCE CARD AT CHECK-IN

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ OTHER ________
SECONDAY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ OTHER ________

PREFERRED METHOD OF CONTACT- PHONE, EMAIL, TEXT, MAIL, OTHER

NEW PATIENT HISTORY

Patient's Name ___________________________________
Date of Birth_____________________________________
Your Relationship to Child _________________________
Present Health Concerns __________________________
____
____
____
Current Medications ______________________________
____
____

CHILD'S BIRTH HISTORY

Hospital of Birth_________________________________
Number of Previous Pregnancies ___________________
Birth Weight_____________________________________
Premature ____________ Full Term ________________
Problems with this pregnancy, labor or delivery?______
____
Problems in the nursery___________________________
____

CHILD'S PAST MEDICAL HISTORY

Illnesses____
____
Hospitalizations __________________________________
____
Surgeries____
____
Injuries____
____
Serious Infections_________________________________
____
Other Medical Problems____________________________
____
Developmental Problems ___________________________
____
____
____

School Problems _________________________________
____
____
Allergies: ______________________________________
____
____

OTHER CHILDREN IN FAMILY

Name	Age	Medical Problems
___________	___________	_________________________
___________	___________	_________________________
___________	___________	_________________________
___________	___________	_________________________

Children not living _______________________________
Cause of death ___________________________________

FAMILY HISTORY

Birth Defects ____________________________________
Bleeding Problems ________________________________
Juvenile Diabetes ________________________________
Seizures ____
Heart Disease (note approx age of onset) ____________
____
High Blood Pressure ______________________________
Stroke____
Allergies ____
Asthma ____
Mental Illness ____________________________________
Attention Deficit Disorder __________________________
Learning Problems ________________________________
Alcohol or Drug Abuse _____________________________
Genetic Diseases __________________________________
Migraines _______________________________________
Obesity ____
Kidney Disease/Urinary Reflux______________________
Thyroid Problems _________________________________
Other ____
____