De La Vega Pediatrics

TODAY'S DATE

PATIENT REGISTRATION FORM - PEDIATRICS

Social Security No.: | First Name: | Middle: | Last:

Sex: ◯ Male ◯ Female

Gender Identity: ◯ Male ◯ Female ◯ Other ◯ Decline to Answer ◯ Transgender Male (Female-to-Male) ◯ Transgender Female (Male-to-Female) ◯ Genderqueer (Neither exclusively Male nor Female)

Sexual Orientation: ◯ Straight ◯ Gay ◯ Lesbian ◯ Bisexual ◯ Other ◯ Unknown ◯ Decline to Answer

Birth Date:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Legally Separated

Race: ◯ Asian ◯ Black/African American ◯ White ◯ American Ind./Alaska Nat. ◯ Native Hawaiian ◯ Pacific Islander ◯ Haitian Black ◯ Haitian White ◯ More Than One Race

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic

Preferred Language:

Employed: ◯ Yes ◯ No

Employer:

Street Address:

Home Phone:

City: | State: | ZIP Code:

Cell Phone:

Email: | Work Phone: | Preferred Method of Contact:

Referral Source: ◯ Referring Provider ◯ Ins. Company ◯ Flyer/Mailing ◯ Walk-In ◯ Hospital ◯ School ◯ Family/Friend ◯ Newspaper ◯ Health Fair/Outreach Event ◯ De La Vega Pediatrics's website ◯ Online ◯ Other/Unknown

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Ins. Carrier: | Pt's Relationship to Subscriber: | Group No.: | Policy No.:

EMERGENCY CONTACT INFORMATION

Parent | Spouse | Child | ◯ Other | Sex: ◯ M ◯ F

First Name: | Middle: | Last:

Preferred Language: | Home Phone: | Cell Phone: | Work Phone:

PARENT / GUARDIAN INFORMATION

◯ Parent | ◯ Spouse | ◯ Child | ◯ Other | Sex: ◯ M ◯ F

First Name: | Middle: | Last:

Social Security No.: | Birth Date: | Preferred Language: | Home Phone: | Cell Phone: | Work Phone:

PREFERRED PHARMACY

Pharmacy Name: | Phone: | Fax:

Street Address or Cross Street: | City: | State: | Zip Code:

De La Vega Pediatrics 

NEW PATIENT HISTORY FORM

Date _____

Name _____ DOB: _____

How were you referred to our practice? _____

Current problems/Concerns _____

Allergies (Medications, Vaccines, Food, others) _____

Current Medications _____

BIRTH HISTORY

Was this child? Full term _____ Pre-term _____ Adopted _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? Vaginal _____C-section _____ If C-section, why? _____

Any problems during the newborn period? _____

Birth weight _____ Breech? Yes _____ No _____

Passed hearing screen? _____ Passed newborn metabolic screen (PKU)? _____

CHILD'S PAST MEDICAL HISTORY	Yes	No
Any Hospitalizations?	☐	☐
Any Surgeries?	☐	☐
Any Emergency room or urgent care visits?	☐	☐

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:		
ADHD/ADD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Seizures	☐	☐
Heart Murmur	☐	☐
Wheezing	☐	☐
Pneumonia	☐	☐
Ear Infections	☐	☐
Chicken Pox	☐	☐
Urinary tract infection	☐	☐
Acne	☐	☐
Serious injury or concussion	☐	☐
Developmental and/or speech problems	☐	☐
For girls only, has she started her menstrual cycle?	☐	☐

Other history of chronic problem? _____

Has your child ever been seen by a specialist? _____ If so, please describe?

_____

De La Vega Pediatrics

HAS YOUR CHILD EVER HAD:

	Yes	No
Fainting during or after exercise, emotion or startle?	☐	☐
Extreme shortness of breath with exercise?	☐	☐
Discomfort, pain, or pressure in chest during exercise?	☐	☐

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early heart attack (under 50 yrs. old)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome (PCOS)	☐	☐	☐	☐
Ear tubes	☐	☐	☐	☐
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

If Other, explain: