EMBER & OAK PEDIATRICS
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Pediatric Intake Form

Intake Date:	Preferred Language:
Person Completing Form:	Relationship to Patient:

Patient Information			
Patient Name:		Age:	DOB:
Ethnicity:	Gender:		
Address:			
Phone:	Email:		
Emergency Contact Name: Phone:	Relationship:		

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Parent(s) Information- If patient is <18 yrs of age	
Mother's Name:	
Address:	
Email:	Phone#:
Father's Name:	
Address:	
Email:	Phone#:
Guardian's Name:	
Address:	
Email:	Phone#:
Who is the Patient's Primary Caretaker? Mother Father Other:	

Insurance Information	
Insurance Name:	
Member ID:	Group Number:
Insurance Phone#:	Effective Date:
Policy Holder's Employer:	Phone#:
Relationship to Insured:	
Person Responsible for Account:	

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Referral Information- If not referred, please provide Pediatrician's information		
Name:		Specialty:
Address:		
Office Phone:	Office Fax:	Email:
Reason for Referral:		

Current Medical Information & Primary Concern	
Primary Care Provider:	Phone #:
List all current physicians and/or practitioners you currently use: **Name** / **Specialty**	
List medical diagnoses:	
1.	5.
2.	6.
3.	7.
4.	8.
Current Medical Concern(s):	

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Medications			
List all known prescriptions, over the counters and vitamins. Past and current. *Attach list if more room is needed.*			
Medication	**Reason for Taking**	**Prescribed By**	**Currently Taking?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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Surgeries/Hospitalizations		
Reason/Surgery	**Hospital/Doctor**	**Date**

Allergies
1.
2.
3.

Scheduled Immunizations Up to Date including HepB, Pneumococcal, DTaP, MMR?: Y☐ N☐	
Flu: Y☐ N☐ Covid: Y☐ N☐ RSV: Y☐ N☐	If your child did not receive recommended childhood vaccines, please note:
Any adverse reactions?	

Additional Concerns or Comments:

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Signature	Printed Name	Date