Patient Registration Form

Patient Information:

First Name: _____ **Middle Name:** _____**Last Name:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female

Address: _____**City:** _____**State:** _____ **ZIP:** _____

Parent/Guardian Name (1): _____ **Relationship to Patient:** _____
Mobile #: (___) _____**Home #:** (___) _____ **Email:** _____

Parent/Guardian Name (2): _____ **Relationship to Patient:** _____
Mobile #: (___) _____**Home #:** (___) _____ **Email:** _____

Is the patient in foster care? ☐ Yes ☐ No

- **If yes, provide name and phone number of case worker:** _____

Primary Insurance Information:

Insurance Name	Policy ID	Group #	Policy Holder Name	Relationship to Patient	Policy Holder DOB

Secondary Insurance Information:

Insurance Name	Policy ID	Group #	Policy Holder Name	Relationship to Patient	Policy Holder DOB

Preferred Pharmacy Information:

Pharmacy Name	Address	Phone #

Current Medications:

Medication Name	Dosage/Strength	Frequency	Purpose (optional)

List of Surgeries:

Surgery Type	Date of Surgery	Location	Doctor Name

Emergency Room or Urgent Care Visits (Last 6 Months)

Date of Visit	Facility Name	City	Reason for Visit

Patient and Family Health History

Medical Condition	Patient	Family Member	Comments (Specify)
Asthma	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Down Syndrome	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Allergies (Specify)	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Diabetes Type l	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Diabetes Type ll	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Heart Disease	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Seizures/Epilepsy	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Cancer (Specify)	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
High Blood Pressure	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
High Cholesterol	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Mental Health Disorders (Specify)	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	
Other (Specify)	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Maternal GP ☐ Paternal GP	

Pediatric Social History Questions

Living Environment

- **Who does the patient live with?** _____
  (Include parents, guardians, siblings, or others in the home)
- **Are there any pets in the home?** ☐ Yes ☐ No
  - **If yes, please specify types of pets:** _____
- **Is the patient exposed to secondhand smoke?** ☐ Yes ☐ No

Lifestyle

- **Does the patient attend daycare, preschool, or school?** ☐ Yes ☐ No
  - **If yes, name of the facility/school:** _____
- **How many hours per day does the patient spend on screens (TV, phone, tablet, etc.)?** _____
- **Does the patient participate in sports or physical activities?** ☐ Yes ☐ No
  - **If yes, which activities/sports?** _____
- **Does the patient have a regular bedtime routine?** ☐ Yes ☐ No
  - **If yes, what time do they typically go to bed?** _____

Safety

- **Does the patient use a car seat, booster seat, or seat belt as required by age/weight?** ☐ Yes ☐ No
- **Are there any firearms in the home?** ☐ Yes ☐ No
  - **If yes, are they secured in a locked location?** ☐ Yes ☐ No

Substance Exposure (if age-appropriate)

- **Has the patient been exposed to drugs or alcohol?** ☐ Yes ☐ No
  (This could refer to indirect exposure, such as substance use by caregivers or within the home.)

Mental and Emotional Health

- **Has the patient experienced any bullying at school or online?** ☐ Yes ☐ No
- **Does the patient have difficulty making or maintaining friendships?** ☐ Yes ☐ No
- **Does the patient have any concerns about their mental health (e.g., sadness, anxiety)?** ☐ Yes ☐ No

Family and Social Support

- **Does the family have access to sufficient food, housing, and other necessities?** ☐ Yes ☐ No
- **Are there any family stressors affecting the patient (e.g., divorce, financial difficulties)?** ☐ Yes ☐ No

Detailed Birth History (For Children 6 and Under)

Birth Details:

- **Place of Birth (City, State, Hospital/Other Location):** _____
- **Type of Delivery (e.g., vaginal, C-section):** _____
- **Type of Feeding (e.g., breastfed, formula-fed):** _____

Birth Statistics:

- **Birth Weight:** _____ lbs. ___ oz. **Length:** _____ inches
- **Was the patient born full term?** ☐ Yes ☐ No
  - **If no, how many weeks at birth?** _____

Complications & NICU Stay:

- **Any complications during pregnancy or delivery?** ☐ Yes ☐ No
  - **If yes, explain:** _____
- **NICU Stay?** ☐ Yes ☐ No
  - **If yes, how long and what for:** _____

Consent and Confirmation:

- **This form confirms that all information provided is accurate and complete. The parent or guardian verifies the accuracy of the information by signing below and consents to the medical use of this data for care purposes.**

Parent or Guardian Name: _____**Relationship to Patient:** _____

Signature of Parent/Guardian: _____**Date:** _____