# PEDIATRIC NEW PATIENT PAPERWORK

Name: _____ Nickname: _____ Date: _____

Why is your child seeing the doctor today? _____

Please list any medicines your child takes including over-the-counter pills or herbs:

_____

_____

Does your child have allergies to any medicines or latex? Yes / No Please list: _____

_____

Please check if your child sees any other providers. Dentist: _____ Optometrist: _____

Are your child's shots up to date? Yes / No / Unknown
(If you have the records with you, please give to the receptionist)

**Birth History (for age less than 1 year)**

Birth Weight: _____ Birth Length: _____

Pregnancy or Delivery Problems? _____

Deliver type: Vaginal or C-section Feeding: Breast or Bottle

**Developmental History**

Are there any concerns with your child's development? (language/motor delay, behavior issues)

_____

_____

**Medical Problems History**

List any surgeries, hospital stays, or injuries: _____

_____

_____

**Family History**

| | Medical Problems | If Deceased, Age and Cause |
|---|---|---|
| Father | | |
| Mother | | |
| Brothers (# ) | | |
| Sisters (# ) | | |
| Grandmother | | |
| Grandfather | | |

Are there any other medical conditions in your family that I should know about?

_____

_____

**Social History**

Lives with: _____

Attend daycare? _____

What grade in school? _____

Exposed to cigarette smoke? _____

Any pets in the home? _____

**PLEASE CHECK IF YOUR CHILD HAS ANY OF THE FOLLOWING**

General
- _____ Not growing well
- _____ Fevers or night sweats

Eyes
- _____ Lazy Eye
- _____ Concerns with vision

Ears/Nose/Mouth/Throat
- _____ Trouble hearing
- _____ Frequent ear infections
- _____ Hay fever
- _____ Bloody Noses

Heart
- _____ Heart racing or skipping beats
- _____ Heart murmur
- _____ Fainting

Respiratory
- _____ Asthma
- _____ Shortness of breath or cough
- _____ Wheezing

Gastrointestinal
- _____ Diarrhea or constipation
- _____ Frequent spit-ups
- _____ Stomach aches

Musculoskeletal
- _____ Fractures/injuries

Skin
- _____ Eczema
- _____ Rashes

Neurologic
- _____ Seizures
- _____ Headaches
- _____ Dizziness or clumsiness

Psychiatric
- _____ Sleep problems
- _____ Behavior problems
- _____ ADHD

Endocrine
- _____ Thyroid Disease
- _____ Diabetes or blood sugar problems

Heme/Lymph
- _____ Excessive bleeding or bruising
- _____ Enlarged lymph nodes

Urinary
- _____ Bed wetting
- _____ Bladder infections

**PATIENT REGISTRATION**
**(Fill out all information. Please Print.)**

Patient's Name: _____ Sex: Male / Female
Birth Date: _____/_____/_____
Guardian: _____
Address: _____
_____
City: _____ State: _____ Zip: _____
Race: Caucasian/ African American/ American Indian/ Asian/ Other
Ethnicity: Non-Hispanic/ Hispanic Language: English/ Spanish/ Other
Home Phone: _____ Mom's cell: _____
Dad's cell: _____ Additional number: _____
Primary Pharmacy: _____ Mail Order Pharmacy: _____

Guarantor (party responsible for portion of bill not paid by insurance)
Name: _____
Address: _____
Phone Number: _____

**ADDITIONAL INFORMATION**

Emergency Contact: _____
Relationship to Patient: _____
Home Phone: _____
Cell Phone: _____

**INSURANCE INFORMATION**

Self Pay (check here if self pay): ☐

Primary Insurance: _____
Subscriber Name: _____
Subscriber's Date of Birth: _____ Relationship to patient: _____

Secondary Insurance: _____
Subscriber Name: _____
Subscriber's Date of Birth: _____ Relationship to patient: _____

**I understand that I am financially responsible for any balance not covered by the insurance.**

Printed Name: _____ Relationship to patient: _____
Signature: _____ Date: _____