Patient Information

Patient Name _____
First M. Last Nickname (if any)

Patient Home Address _____

_____
City State Zip Phone Number Cell Number

Patient Age _____ Date of Birth _____ Sex M F Patient SSN _____
(required by most insurance to process claims)

Patient Grade Level and School _____

Parent/Guardian's Name (1) _____

Parent/Guardian's Name (2) _____

Siblings: Number of Brothers _____ Number of Sisters _____ Are Siblings existing patients? Yes No

Patient's Primary Care Doctor _____

Patient Health History

(Questions asked so hereditary and environmental factors can be evaluated)

Birth History

Was this child premature? . . . . . Yes No
If premature, how many weeks? _____
Please note any prescription medicine taking during pregnancy _____
Were there any problems during pregnancy? . . . . . Yes No
Were there any problems with the delivery? . . . . . Yes No
Is this child adopted? . . . . . Yes No

General Health

Is a physician currently treating your child for a specific problem? . . . . . Yes No
If so, for what reason? _____
Is your child taking medication at this time? . . . . . Yes No
Drug _____ Dose _____ Frequency _____ Reason _____
Drug _____ Dose _____ Frequency _____ Reason _____
Drug _____ Dose _____ Frequency _____ Reason _____
Please note any past prescription medications _____
Has your child shown any allergies or unusual reactions to medications (e.g. penicillin and amoxicillin) or substances such as latex or nickel? _____
Are your child's immunizations up to date? . . . . . Yes No
Does your child receive a yearly flu shot? . . . . . Yes No