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NEW PATIENT INFORMATION

Demographics

CHILD'S INFORMATION

Child's Last Name, First Name: _____

Birth Date: _____

Sex: ☐ Male ☐ Female

Telephone #: _____

Street Address: _____

Apt #: _____

City: _____ State: _____ Zip Code: _____

Language: ☐ English ☐ Spanish ☐ Other: _____

PARENTS / GUARDIAN INFORMATION

Mother's Name: _____

Cell: _____

Email: _____

Address: _____

DOB: _____

Father's Name: _____

Cell: _____

Email: _____

Address: _____

DOB: _____

Consent to enroll in online patient portal (please circle one): YES / NO

Consent to receive text messages for Appointment Reminders (please circle one): YES / NO

Insurance

Insurance Name: _____

ID #: _____

Group #: _____

Guarantor's Name & DOB: _____

Guarantor's Relationship to Child: ☐ Self ☐ Mother ☐ Father ☐ Other: _____

Secondary Insurance

Insurance Name: _____

ID #: _____

Group #: _____

Guarantor's Name & DOB: _____

Guarantor's Relationship to Child: ☐ Self ☐ Mother ☐ Father ☐ Other: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____

Address: _____

Phone Number: _____

MEDICAL HISTORY

FAMILY MEDICAL HISTORY

Please mark X in the boxes for all family members that have any of the following conditions:

Diagnosis	Siblings	Mother	Father	Maternal Grandparents Please Specify	Paternal Grandparents Please Specify
Anxiety/Depression	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐

Sudden Cardiac Death	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

Continue to the next page.

BIRTH HISTORY

Gestational Age at Birth: _____

Birth Weight: _____

Type of Delivery: ☐ Vaginal Delivery ☐ C-Section

Birth Hospital: _____

Complications During Pregnancy: _____

Birth Complications (if any): _____

Feeding Complications (if any): _____

ALLERGIES & MEDICATIONS

Allergies: ☐ Yes ☐ No

Medications: _____

Food: _____

Other: _____

Current Medications: ☐ Yes ☐ No

List all medications with dosage and frequency:

_____

_____

_____

PAST MEDICAL HISTORY

Has your child ever had any of the following? (check all that apply)

☐ ADHD

☐ Anxiety

☐ Autism Spectrum Disorder

☐ Asthma

☐ Allergies

☐ Chronic Lung Disease

☐ Depression

☐ Developmental Delay

☐ Learning Disability

☐ Cerebral Palsy

☐ Chronic Ear Infections

☐ Heart Disease

☐ Hypertension

☐ Kidney Disease

☐ Gastroesophageal Reflux Disease

☐ Feeding Difficulties

☐ Skin Disorder, such as eczema

☐ Headaches

☐ Thyroid Disease

☐ Seizure Disorder

☐ Other _____

PAST SURGICAL HISTORY

Type of Surgery:	Date:
Type of Surgery:	Date:
Type of Surgery:	Date:

FAMILY / SOCIAL HISTORY

Is child living with: ☐ Mother ☐ Father ☐ Both ☐ Grandparents ☐ Other: _____

Siblings: ☐ Yes ☐ No How many? _____

Secondhand Smoke Exposure: ☐ Yes ☐ No

Daycare: ☐ Yes ☐ No

School Grade: _____

Does the child have an IEP or 504 at school?: ☐ Yes ☐ No

Are there any guns in the home?: ☐ Yes ☐ No

If yes, are they properly secured?: ☐ Yes