**EXPRESS PEDIATRIC CARE**

**New Patient Information Form**

***Please provide a copy of all legal documents stating parent/guardian responsibilities to include in the patient's record.**

## *PATIENT INFORMATION*

Name: ________________________________________ Date of Birth: _______________________

Social Security Number: __________________________ Gender:(circle one) Female Male

Preferred Language: _____________________________ Race: ______________________________

Mailing Address: ________________________________ Ste/Apt #: ___________________________

City: ________________________________ State: ______________________ Zip Code: ________

Home Phone: ___________________________________ Cell Phone: _________________________

Email Address: _________________________________ Preferred Method of Contact: __________

## *PARENT/GUARDIAN INFORMATION*

Father's Name: _______________________________ Date of Birth: ______________________

Mother's Name: _______________________________ Date of Birth: ______________________

If parents are legally separated or divorced, who has legal custody? ______________________________

Which parent is financially responsible for medical expenses? __________________________________

Legal Guardian Address if different from patient's: ___________________________________________

Legal Guardian Phone if different from patient's: ____________________________________________

***Please provide a copy of the legal documentation stating the parent responsibility for medical expenses to be included in the patient's medical records. ***

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## *INSURANCE INFORMATION*

Primary Insurance: ______________________________________ ID#: ____________________________

Primary Insured Name: _______________________________ Group #: _________________________

Primary Insured's Date of Birth: ______________________ Relationship to Patient: _____________

Insured's Employer: _________________________________ Employer's Number: _______________

Secondary Insurance: ______________________________________ ID#: __________________________

Secondary Insured Name: _______________________________ Group #: _______________________

Secondary Insured's Date of Birth: _______________________ Relationship to Patient: ___________

Insured's Employer: ________________________________ Employer's Number: _____________

Parent/Guardian Signature: _______________________________ Date: __________________________

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## *INITIAL HISTORY QUESTIONAIRE*

**Form Completed By: ________________________________ Date Completed: ________________**

__________________________________________________________________________________Pa
tient Name Birth Date Age Gender

***Household*** *(Please list all those living in the child's home.)*

| *Name* | *Relationship to Child* | *Birthdate* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are there siblings not listed? If so, please list their names, ages, and where they live. ______________

__________________________________________________________________________________

_________________________________________________________________________________Wha
t is the child's living situation if not with both biological parents?

▫ Lives with adoptive parents ▫ Joint Custody ▫ Single Custody ▫ Lives with foster family

▫ Other: __________________________________________________________________________

*Please be aware all legal court documents most be provided for any of the above choices at the time of visit to keep in patient's record. *

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***Birth History*** ▫Don't Know birth history

Birth weight: _______ Gestational Age: _____________ Delivery was: ▫ Vaginal ▫ Cesarean

Were there any prenatal or neonatal complications? Explain: __________________________________

Was a NICU stay required? Explain: ______________________________________________________

During pregnancy, did mother use: **Tobacco** ▫ Yes ▫ No **Alcohol** ▫ Yes ▫ No **Drugs** ▫ Yes ▫ No

Initial Feeding: ▫ Formula ▫ Breastmilk How long was breastfeeding continued? _______________

Did the baby go home with mother from hospital? Explain: ___________________________________

***General*** DK=don't know

Do you consider your child to be in good health? Explain: ____________________________________

Does your child have any serious illnesses or medical conditions? Explain: ______________________

Has your child had any surgeries? Explain: _______________________________________________

Has. your child ever been hospitalized? Explain: ___________________________________________

Is your child allergic to medicine or drugs? Explain: _________________________________________

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***Biological Family History*** *(Have any family members had the following?) DK= don't know*

Childhood hearing loss? Who: ______________________________________________________

Nasal allergies? Who: _____________________________________________________________

Asthma? Who: ___________________________________________________________________

Tuberculosis? Who: _______________________________________________________________

Heart Disease (below 55 years old)? Who: ____________________________________________

High Cholesterol? Who: ___________________________________________________________

Bleeding Disorder? Who: __________________________________________________________

Liver Disease? Who: ______________________________________________________________

Kidney Disease? Who: _____________________________________________________________

Diabetes (below 55 years old)? Who: _________________________________________________

Obesity? Who: ___________________________________________________________________

Epilepsy or Convulsions? Who: ______________________________________________________

Alcohol Abuse? Who: ______________________________________________________________

Drug Abuse? Who: ________________________________________________________________

Mental Illness/Depression? Who: _____________________________________________________

Developmental Delay? Who: _________________________________________________________

Immune Problems, HIV, or AIDS? Who: ______________________________________________

Tobacco use? Who: ________________________________________________________________

Dental Decay? Who: _______________________________________________________________

Cancer (below 55 years old)? Who: ___________________________________________________

Additional Family History: __________________________________________________________

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***Past History*** *(Does your child have, or has your child ever had) DK= don't know*

Chicken Pox? When: ___________________________________________________________________

Frequent ear infection/Problems with hearing? Explain: ________________________________________

Nasal Allergies? Explain: ______________________________________________________________

Problem with eyes or vision? Explain: ____________________________________________________

Asthma, bronchiolitis, or pneumonia? Explain: ______________________________________________

Any heart problems or murmur? Explain: __________________________________________________

Anemia or bleeding problem? Explain: ____________________________________________________

Convulsions or other neurological problems? Explain: _______________________________________

Organ transplant? Explain: _____________________________________________________________

Malignancy/bone marrow transplant? Explain: _____________________________________________

Cancer or chemotherapy? Explain: _______________________________________________________

Constipation requiring doctor visits? Explain: ______________________________________________

Recurrent urinary tract infections? Explain: ________________________________________________

Obesity? Explain: ____________________________________________________________________

Metabolic/Genetic Disorders? Explain: ___________________________________________________

Kidney Disease or Urologic Malformations? Explain: ________________________________________

Sleep Problem / Snoring? Explain: _______________________________________________________

Chronic or Recurrent Skin Problems (Acne, Eczema)? Explain: ________________________________

ADHD/Anxiety/Depression/Mood Problems? Explain: ________________________________________

Developmental Delay? Explain: _________________________________________________________

History of family violence? Explain: ______________________________________________________

Sexual transmitted infections? Explain: ___________________________________________________

Any other significant problem? _________________________________________________________

Parent/Guardian Signature: ___________________________________ Date: _________________