Whole Child Pediatrics

PATIENT INFORMATION FORM
(PLEASE PRINT)

Patient's Name Last:	First:	Mid:	D.O.B:	Age:	Sex: ☐ M ☐ F
Street address:	City:	State:	ZIP:	Home#:	
Mother's Name Last:	First:	Mid:	D.O.B:	Age:	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Street address:	City:	State:	ZIP:		
Home#:	Work #:	Cell # :	Email:		
Father's Name Last:	First:	Mid:	D.O.B.	Age:	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Street address:	City:	State:	ZIP:		
Home#:	Work #:	Cell #:	Email:		

Do parents reside together? Yes/No	Who does the child live with? Mother ☐ Father ☐	Other
Other Children:	Male/ Female D.O.B:	Nickname:
1.		
2.		
3.		
4.		
5.		

Why did you choose Whole Child?
☐ Family ☐ Friend ☐ Close to home/work ☐ Website ☐ Other Comment:

INSURANCE INFORMATION

Primary Insurance:				Effective Date:
Claims Address:	City:	State:		Zip:
Name of Policyholder:	Policy#:	SS#:	Group#:	Co Pay : $
Secondary Insurance:				Effective Date:
Claims Address:	City:	State:		Zip:
Name of Policyholder:	Policy#:	SS#:	Group#:	Co Pay: $
Employer Name:				Work #:
Address:	City:	State:		Zip:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home#:	Cell or Work #:
address:	City:	State:	Zip:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Whole Child Pediatrics. I understand that I am financially responsible for any balance. I also authorize Whole Child Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian Signature: ***Date:***

BIRTH HISTORY		
Child's Name:	**D.O.B:**	**Today Date:**
Birth Order:		
Place of Birth:		
Mother's Age at time of birth?		
Any prenatal complications? Yes ☐ No ☐		
Is Yes, what kind?		
Full term? Yes ☐ No ☐ If not, how many weeks:		
Maternal grp B strep: Positive ☐ Negative ☐		
If mom was positive was she given intrapartum antibiotics? Yes ☐ No ☐		
How many doses did she receive?		
If a CBC was done, what were the results?		
Any history of herpes? Yes ☐ No ☐		
Maternal blood type:		
Mode of delivery: Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum ☐		
Birth weight: Apgars:		
Baby's blood type (if done):		
Did baby receive? Vitamin K Erythromycin eye		
If male, was he circumsized? Yes ☐ No ☐		
Did the baby pass the hearing screen? Yes ☐ No ☐		
If no, what is the planned follow up?		
Was a PKU done: Yes ☐ No ☐		

PAST MEDICAL HISTORY

Does your child have any allergies to medication?
Any food allergies?
Is your child currently taking any medications?
Is your child taking any herbs or vitamins?
Does your child have asthma? Yes ☐ No ☐ **What medicine do they use?**
Is there history of frequent ear infections? Yes ☐ No ☐
If yes, when was the last one?
Have they been seen by a ENT? Yes ☐ No ☐ **Do they have tubes?**
Is there a history of urinary tract infections? Yes ☐ No ☐ **If Yes, indicate dates below:**
Date: **Date:** **Date:** **Date:** **Does your child have any other conditions we should be aware of or do you have any other concerns about your child's health at this time?** **Immunizations up to date?** Yes ☐ No ☐

FAMILY HISTORY

Family Name:	
Is there any history of the following diseases in your family and if so who?	
Alcoholism or Drug Dependency:	
Allergies:	**Asthma:**
Bleeding Disorder:	**Cholesterol (high):**
Cancer:	**Eating Disorder:**
Diabetes:	**Heart Disease or Hypertension:**
Eczema:	**Kidney:**
Immunodeficiency:	**Menstrual Problems:**
Lupus:	**Psychiatric Disorder:**
Migraines:	**Stroke:**
Seizures:	**Sudden Death:**

SOCIAL HISTORY
Mother's Employment:
Father's Employment:
Do parents live together?
If not what is the custody arrangement?
Birth dates of all children in the family:
Do extended family live in the home with the child(ren)?
Religion Preference:
Does anyone smoke in the home?
Any animals at home?