



PATIENT INFORMATION

Patient name: _____
Address: _____ Nickname of child: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Social Security #: _____
Sex: (M/F) _____ Date of Birth: _____
Father/ Guardian name: _____ Mother/Guardian name: _____
Child lives with: _____

INSURANCE INFORMATION

Primary Insurance Company: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____
Insured name (Policyholder): _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ DOB: _____ Sex: _____ Marital Status _____
Relationship to patient: _____ Policy or group #: _____
Identification #: _____ Policy type: Employer __ Group __ Non-Group __
Employer name: _____ Employer Address: _____
Employer City: _____ State: _____ Zip: _____
Work Phone#: _____

Secondary Insurance Company (if applicable): _____
Address: _____
City: _____ State: _____ Zip: _____
Insured name: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ DOB: _____ Sex: _____ Marital Status: _____
Relationship to the Patient: _____ Policy or Group #: _____
Identification #: _____
Policy Type: EMP __ Group __ Non-Group __ Medigap __ Medicaid __ Supplement __
Employer name: _____
Employer Address: _____
Employer City: _____ State: _____ Zip: _____
Work Phone #: _____

Please include any additional insurance information on the back of this sheet.

I authorize the release of any information necessary to process my insurance claims. I assign and request payment directly to Forest Pediatrics. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____



PEDIATRIC HISTORY

<u>Pregnancy complications:</u>	Yes	No
Premature delivery	___	___
High Blood Pressure	___	___
Toxemia	___	___
Medications: (if yes, list)	___	___

Bleeding (if yes, what month)	___	___
Serious illnesses	___	___
Infections	___	___
Previous miscarriages	___	___
C-Section (if yes, why)	___	___

Birth History:
 Place of Birth: _____
 Birth Weight: _____
 Length: _____ Hours in labor: _____
 Adopted? (Y/N) _____

<u>Problems at Birth</u>	Yes	No
Jaundice	___	___
Breathing problems	___	___
Antibiotics	___	___
Cord around neck	___	___
Other problems (explain):	_____	

Breast : _____ Formula: _____

Development: At what age did your child:
 Smile: _____ Roll over: _____ Sit alone: _____
 First tooth: _____ Walk Alone: _____ Use 1st word with meaning: _____ Use 3
 word sentences: _____ Bladder trained: _____ Bowel trained: _____
 Ride tricycle: _____ Tie Shoes: _____

Hospitalizations and operations: Date

1) _____

2) _____

3) _____

4) _____

5) _____

Serious or Chronic Illness?

<u>Child's Illness</u>	Yes	No	Date
Chicken Pox	___	___	___
Meningitis	___	___	___
Pneumonia	___	___	___
Diabetes	___	___	___
Seizures	___	___	___
Sickle cell	___	___	___
Allergies	___	___	___
Asthma	___	___	___
Whooping cough	___	___	___
Measles	___	___	___
Mumps	___	___	___
Urinary tract infections	___	___	___
Congenital heart disease	___	___	___

Medications child takes routinely

School problems? (Y/N) _____
 Describe _____

Allergies to Medications:



Form reviewed by: _____ MD/NP

Pt. name & DOB _____

Social History:

Smokers in household (Y/N) _____

Child's family	Age	Present Health or Cause of Death
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Pets: (list) _____

Mother _____

Father _____

Child lives with? _____

Siblings' names _____

Any social issues we should be aware of? _____

Family Medical History:

Mother's side

Father's side

Diabetes _____

Heart problems _____

High blood pressure _____

Stroke _____

Cancer _____

Tuberculosis _____

Ulcer _____

Arthritis _____

Obesity _____

Depression _____

Suicide _____

Other mental illness _____

Thyroid problems _____

Sickle Cell _____

Seizures _____

Bed wetting _____

Allergies _____

Asthma _____

Food Allergies _____

Sinus problems _____

Growth delay _____

Genetic disorders _____

Is there anything else we should know in order to better care for your child? _____

Reviewed by _____ MD/NP Name & DOB _____