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NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Sex: M F

Address: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

How did you hear about our practice? _____

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Emergency Contact (other than parent): _____

Relationship to Child: _____ Phone: _____

Primary Insurance

Name of Insurance Co: _____ Policy/ID#: _____ Group#: _____

Insurance Mailing address: _____

Subscriber Name _____ Date of Birth: _____ Relationship to patient: _____

SS#: _____ Employer: _____ Effective date: _____

Secondary Insurance

Name of Insurance Co: _____ Policy/ID#: _____ Group#: _____

Insurance Mailing address: _____

Subscriber Name _____ Date of Birth: _____ Relationship to patient: _____

SS#: _____ Employer: _____ Effective date: _____

I understand that, even though I may have some type of insurance and authorize this office to submit charges on behalf of my child, I am also responsible for payment. I hereby assign the doctor, all payments for medical services rendered on my dependent. I am aware that **copayment is required at each visit**, and if there is no insurance coverage, payment in full is required for services provided unless prior payment arrangements have been discussed. **I will also be responsible for all collection fees, should my account be assigned to a collection agency.**

Signature: _____ Date: _____

Patient Name: _____ DOB _____
 Mother's Name: _____ Age: _____
 Mother's Occupation: _____ Highest Level of Education Completed: _____
 Father's Name: _____ Age: _____
 Father's Occupation: _____ Highest Level of Education Completed: _____
 Parent's Marital Status: married single divorced separated widowed re-married significant other
 Who lives in the home with this child? Number of adults: _____ Number of children: _____
 How long has child been in your care? _____
 Emergency Contact Name/Telephone Number: _____
 Please list the names and birthdates of brothers and sisters:
 Name: _____ Date of Birth: _____ Health Status: _____
 Name: _____ Date of Birth: _____ Health Status: _____
 Name: _____ Date of Birth: _____ Health Status: _____
 Name: _____ Date of Birth: _____ Health Status: _____
 Pets: Yes No Type and #: _____ Type of Home: Apartment Trailer-Home House
 Smokers in Household? Yes/ No Who? _____ Water Source: City Well Bottled County
 What children's health reference books do you have in your personal library? _____
 Is your child up-to-date on immunizations? _____

MEDICAL HISTORY

Pregnancy History	Y	N	Don't know	Comments & Dates
Medications (Please List)				
Street Drugs (Please List)				
Alcohol				
Smoking				
Vaginal Infection				
Urine Infection				
Other Problems (Please List)				

Birth History	Comments
How long was the pregnancy?	
Where was the baby born?	
What was the baby's birth weight / length?	
How long did the baby stay at the hospital?	
Was the delivery vaginal or by c-section?	
Did the baby have any problems?	

Patient's Medical History	Y	N	Don't know	Dates & Comments
Has your child ever been hospitalized overnight?				
Has your child ever had surgery?				
Does your child have any allergies? To what?				
Does your child get regular dental care? Please provide name of Dentist:				
Is your child on any medications? Please list.				
Has your child gone to an ER this past year?				

Patient Name: _____ DOB _____

Has your child ever had any of the following:				
Ear Infections				
More than 2 strep throats				
Pneumonia				
Heart problems				
Chickenpox				
Any major illness				
Reaction to any immunizations or medications				
Urinary tract infection				
Wheezing				

Family History: Please check if close blood relatives have the following diseases/conditions or currently taking any medications.

Disease	Y	N	Who?	Disease	Y	N	Who?
Asthma				Heart attack/bypass			
Cancer				Kidney/Urine infection			
Cystic Fibrosis				Allergies/Hayfever			
Thyroid Problems				High blood pressure			
High cholesterol				Anemia/Sickle Cell			
Diabetes (Type 1 or 2)				Learning Problems			
Hyperactivity				Seizures			
Developmental problems				Emotional Problems			
Sudden Death				Born with heart problems			
Birth Defects				Death shortly after birth			

School / Daycare Behavior History	Y	N	Don't know	Dates & Comments
Child's school & Grade:				
Does child attend special classes or receive special help?				
Are you concerned about school behavior problems?				
Does your child have problems with:				
Frequent nightmares				
Difficult to control				
Fighting a lot				
Trouble making friends				
Bedwetting or stooling problems				
Vision / Hearing				
Appetite				

Name of child's previous doctor: _____ Phone #: _____

Address: _____

Are there any specific issues you would like to discuss with the doctor? _____

By signing below, I affirm that I am the parent or legal guardian of the patient and that all information completed above is true to my knowledge:

Signature: _____ Date: _____ Relationship: _____

Physician Signature: _____ **Date:** _____

Patient Name: _____ DOB _____