

# Welcome!

ABOUT YOUR CHILD	FAMILY INFORMATION
Today's Date: / /	Parent's Marital Status:
Child's Name:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Child's Nickname: <input type="checkbox"/> F <input type="checkbox"/> M	
Birth Date: / / Current Age:	Mother's Name:
Child's Home Address:	<input type="checkbox"/> Biological <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian
	Mother's current physical health is:
City: State: Zip:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Child Resides With:	Birth date: / / Home Phone:
	Employer: Work Phone:
Referred by:	Social security #:

WHO IS ACCOMPNYING THIS CHILD TODAY	
Name:	Father's Name:
Relation:	<input type="checkbox"/> Biological <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian
Are you the legal guardian of this child?	Father's current physical health is:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Birth date: / / Home Phone:
	Employer: Work Phone:

YOUR CHILD'S MEDICAL HISTORY	
List any allergies your child has:	Social security #:
	Who is responsible for making appointments?
	<input type="checkbox"/> Mother <input type="checkbox"/> Father
List current medications prescription/over the counter:	Name:
	Home Phone:
	Work Phone:

List previous surgeries/treatments with date:	Please list all other family members residing at current address: (including gender & birth date)
Has your child had any of the following illnesses? Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Cancer <input type="checkbox"/> Pneumonia <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Diabetes <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other Illnesses: _____	

<b>INSURANCE INFORMATION</b>
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**Primary Insurance Co.**

Name:	ID No.:
Address:	Group No.:
Phone:	
Insured's Name:	Insured's SS#:
Birth Date:	Relation:
Insured's Employer	

**Secondary Insurance Co.**

Name:	ID No.:
Address:	Group No.:
Phone:	
Insured's Name:	Insured's SS#:
Birth Date:	Relation:
Insured's Employer	

**In the event of an emergency whom should we contact?**

Name:	Relation:
Work Phone:	Home Phone:

<b>ACCOUNT INFORMATION</b>
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**Person Responsible for Account**

Name:	Relation:
Billing Address:	City: State: Zip:
Home Phone:	Work Phone:
SS#:	Drivers Lic. No.:

We invite you to discuss frankly with us any questions regarding our services. The best health services are those based on a friendly, mutual understanding between provider, parent and patient.

I understand the above information, guarantee this form was completed correctly to best of my knowledge and understand it is my responsibility to inform this office of any changes in my child's medical status.

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Signature of Responsible Person

Date: