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 ointment
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?