Medical Record Number: _____

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Patient Information

Legal Name (Last / First / Middle)			Nickname
Social Security Number	Birth Date	☐ Male ☐ Female	Marital Status ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed
Street Address	Zip	City	State
Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Preferred Contact Method ☐ Text ☐ Phone ☐ Email ☐ Other	
Email **Required*	Occupation	Employer	
Primary Care Provider	Referring Provider		

As part of the American Recovery and Reinvestment Act, healthcare providers are required to obtain the following information. Please check the boxes in section 1-3 that most apply to you.

1. Race (Choose One)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White / Caucasian

2. Ethnicity (Choose One)

☐ Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Declined to Specify

3. Preferred Language (Choose One)

☐ Arabic ☐ English ☐ Hebrew ☐ Korean ☐ Spanish/Castilian ☐ Urdu
☐ Bulgarian ☐ French ☐ Hindi ☐ Polish ☐ Somali ☐ Vietnamese
☐ Chinese ☐ German ☐ Italian ☐ Portuguese ☐ Swahili ☐ Declined to Specify
☐ Central Khmer ☐ Haitian ☐ Japanese ☐ Russian ☐ Thai

Responsible Party (Policy Holder) / Legal Guardian *if minor, please have parent or legal guardian complete the following.*

☐ Self

Legal Name (Last / First / Middle)		Relationship to Patient ☐ Parent ☐ Other ☐ Spouse	Birth Date
Social Security Number	Address		☐ Check here if same address as above
Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer	

Emergency Contact

Name (Last / First / Middle)			Relationship to Patient
Address			
Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer	

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Insurance

Primary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date
Secondary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date

Medications *include over-the-counter medications and supplements.* ☐ *check box if NO medications.*

Drug Name	Dosage Strength (i.e., mg/mcg)	How many times a day?
1		
2		
3		
4		
Attach additional list if there are more medications		

Allergies ☐ *check box if there are NO medication allergies.*

Drug Name / Drug Class / Food	Reaction
1	
2	
3	
4	

Preferred Local Pharmacy

Name _____ Location _____

Phone _____ Fax _____

Medical History *check all that apply. Describe details of medical conditions in spaces below.*

☐ ADHD
☐ allergies (nasal)
☐ anxiety
☐ asthma
☐ concussion
☐ Constipation requiring doctor's visits
☐ depression
☐ developmental delay
☐ diabetes ☐ type 1 ☐ type 2
☐ ear infections (frequent)
☐ eczema
☐ GERD
☐ hearing problems
☐ heart murmur
☐ kidney problems
☐ learning disability
☐ metabolic disorder
☐ migraine headaches
☐ seizures
☐ thyroid problems
☐ urinary tract infections
☐ vision problems

(for Girls)
☐ problems with menstrual period
Age of First menstrual period _____

☐ Other:

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Hospitalizations

Reason	Hospital	Date

Surgeries *check all that apply. Describe details of surgery in spaces below.*

☐ adenoidectomy	☐ gallbladder
☐ appendectomy	☐ hernia repair ☐ belly button ☐ groin
☐ circumcision	☐ tonsillectomy
☐ dental surgery	☐ tubes (ear drum tubes)
☐ Other:	

Family History *check condition and indicate which relative has the condition*

☐ ADD/ADHD	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ alcoholism	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ anemia	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ asthma	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ bleeding disorder	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ deafness	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ depression	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ diabetes, type _____	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ high blood pressure	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ high cholesterol	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ migraines	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ seizure	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ sudden unexplained death before age 50	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ thyroid disease	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ ulcerative colitis	☐ mother	father	☐ brother	☐ sister	☐ other _____
☐ other _____	☐ mother	father	☐ brother	☐ sister	☐ other _____

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Social History *your answers help determine your risk for certain diseases. Responses are confidential.*

Parents Marital Status:

☐ Divorced ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Single ☐ Widowed

Father's Name_____ Age _____

Mother's Name_____ Age _____

Sibling's Name_____ Age _____

Sibling's Name_____ Age _____

Sibling's Name_____ Age _____

Sibling's Name_____ Age _____

Do you have any religious or spiritual preferences that would affect your healthcare?

Tobacco Use

Is the patient exposed to tobacco smoke? ☐ Yes ☐ No

Does the patient... ☐ smoke a pipe ☐ smoke cigarettes ☐ chew tobacco

How many... packs per day? _____

years? _____

If quit, what year? _____

Does the patient have a history of alcohol or drug use? ☐ Yes ☐ No

Has the patient been in foster care? ☐ Yes ☐ No

Has the patient been adopted? ☐ Yes ☐ No

Has the patient experienced difficulties in school? ☐ Yes ☐ No

If yes, please describe.

Immunizations

A copy of the current vaccine record must be provided at the initial appointment.

Immunizations are up to date: ☐ Yes ☐ No If no, please provide reason.

Vaccination	Date	Date	Date	Date
Chicken Pox (Varicella)				
Hepatitis A				
Hepatitis B				
HPV (Gardasil)				
Influenza				
Meningococcal				
MMR				
Pneumonia PCV13				
Tetanus, Diphtheria, Pertussis (Tdap)				
DTAP				
IPV (Polio)				
HIB				

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Birth History

Hospital of birth _____ City/State _____

Group B step screen ☐ positive ☐ negative

Maternal illness/complications _____

Type of delivery ☐ vaginal ☐ cesarean section, reason: _____

Time of birth _____ ☐ AM ☐ PM

Gestational age at birth (how many weeks pregnant)? _____ weeks

Birth weight _____ pounds _____ounces

Birth length _____ inches

Baby received vitamin K shot?		☐ Yes	☐ No	☐ unknown
Baby received hepatitis B shot?		☐ Yes	☐ No	☐ unknown
Hearing test at birth?	Right Ear	☐ Pass	☐ Fail	☐ unknown
	Left Ear	☐ Pass	☐ Fail	☐ unknown

Baby's blood type? _____

Jaundice?	☐ Yes	☐ No	☐ unknown
Required light therapy for jaundice?	☐ Yes	☐ No	☐ unknown
Baby stayed in NICU?	☐ Yes	☐ No	☐ unknown
Feeding history?	☐ Breast	☐ Bottle	☐ Both

Formula type, if applicable _____

What date did the baby leave the hospital? _____

Baby's weight at discharge _____ pounds _____ ounces