Patient Name: _____ SSN #: _____
LAST FIRST MIDDLE

DOB _____ **Place of Birth** _____ **Sex:** ❑M ❑F Race _____

Dad's address: Street_____ Apt___ City _____Zip_____ SSN_____

Mom's address: Street_____ Apt___ City _____Zip_____ SSN_____

Phone Dad: Home:_____Email _____ Work:Cell: _____

Phone Mom: Home:_____Email _____ Work: _____ Cell: _____

Emergency Phone #s: Home:_____ Other: _____ Relationship: _____

Referred By: _____ PREFERRED PROVIDER:_____

ALLERGIES	Birth History	Maternal Labs
	Hospital: _____	Blood type ____ Rh ____
	Term: ❑ Yes ❑ No ❑ WGA	GBS ❑pos ❑neg ❑unk
	Birth wt:_____lbs _____ oz	HepBsAg ❑pos ❑neg
	Length:_____ in/cm	VDRL ❑pos ❑neg
	Vaginal:❑Yes ❑No C-section ❑Yes ❑No	HIV ❑pos ❑neg
	Why:_____	Rubella ❑Imm ❑NR
	Complications? _____	

Chronic Illnesses ❑ Yes ❑ No **Chronic/Long-Term Medications** ❑ Yes ❑ No **Surgeries** ❑ Yes ❑ No

	NAME	DOSE	HOW OFTEN	

Family	Name	DOB	Health History	Family History	Social History
Mother				Asthma: ❑ Yes ❑ No	Lives with whom?
				Allergies: ❑ Yes ❑ No	
Father				Heart Disease: ❑ Yes ❑ No	Parents:
				High Cholesterol: ❑ Yes ❑ No	❑ Married ❑ Divorced
Sibling Full / Half				Cancer: ❑ Yes ❑ No	Daycare: ❑ Yes ❑ No
				Diabetes: ❑ Yes ❑ No	
Sibling Full / Half				Sickle Cell: ❑ Yes ❑ No	Pets: ❑ Yes ❑ No
				Depression: ❑ Yes ❑ No	❑ Indoor ❑ Outdoor
Sibling Full / Half				Mental Disorder: ❑ Yes ❑ No	Exposure to
				ADHD: ❑ Yes ❑ No	smoking: ❑ Yes ❑ No
Sibling Full / Half				Seizures: ❑ Yes ❑ No	Foreign Travel:
				HIV: ❑ Yes ❑ No	❑ Yes ❑ No
Sibling Full / Half				Hepatitis: ❑ Yes ❑ No	Exposure to
				Anemia: ❑ Yes ❑ No	drugs: ❑ Yes ❑ No
				Genetic: ❑ Yes ❑ No	If yes, what kind:_____
				Tuberculosis: ❑ Yes ❑ No	_____
				Other: ❑ Yes ❑ No If yes, what: _____	

SIGNATURE/ACKNOWLEDGEMENT OF PARENT OR GUARDIAN

I hereby authorize the release of any medical information necessary to process the claim. I also request payment of government benefits and authorize payment of medical benefits to the physician or supplier of service.

Signature: X_____ Date: _____