PATIENT INTAKE FORM

Office Use Only

MRN # PCP AS AL

Name Date of Birth Social Security Number

Address Gender

Home Phone Email

Preferred Contact Method ☐Home ☐Cell Would you like to receive text notifications? ☐ Yes ☐ No Would you like to receive email notifications? ☐ Yes ☐ No

Parent/Guardian Information

Name Date of Birth Social Security Number

Address Gender

Cell Phone Work Phone Employer

Other Parent/Guardian Information

Name Date of Birth Social Security Number

Address Relation to Patient

Cell Phone Work Phone Employer

Insurance Information

Policy Holders Name Date of Birth

Address Relation to Patient

Insurance Name Policy/ID # Group #

Address

Phone Referrals Required? ☐ Yes ☐ No

Does your plan require a: ☐ Copay $_____☐ Co-Insurance ____% ☐ Deductible $_____

Person Responsible for Payment Address Phone

Secondary Insurance Information

Subscriber's Name Date of Birth

Insurance Name Policy/ID # Group #

Address

Phone Referrals Required? ☐ Yes ☐ No

Pharmacy

Name Address

Phone

(Exisisting Patients Provide Necessary Updates)

New Patients Only

Prenatal History (Foster/Adoptive Parents-Fill out to the best of your ability)

Mother's Pregnancy: ☐Normal ☐Complications Birth Location: ☐Hospital_____ ☐Birthing Center ☐Home ☐Other_____

Delivery: ☐Vaginal ☐C-Section ☐Induced - Complications: ☐No ☐Yes Birth Weight: _____lbs oz ____Length: _____inches

PRESENT HEALTH CONCERNS Please list most important health concerns in their order of significance

PAST MEDICAL HISTORY MEDICATIONS: Please list all medication + over the counter medications that your child is taking with dosages

1._____ 2._____ 3._____ 4._____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1._____ 2._____ 3._____ 4._____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

Medications:

1._____ 2._____ 3._____ 4._____

Environment:

1._____ 2._____ 3._____ 4._____

Food

1._____ 2._____ 3._____ 4._____

PAST MEDICAL HISTORY CHILDHOOD ILLNESSES:

(Circle and indicate age of illness OR mark C for current as it applies to your child)

Allergies	No Yes/Age	Mononucleosis	No Yes/Age	Alcohol use	No Yes/Age
Asthma	No Yes/Age	Headaches	No Yes/Age	Drug Abuse	No Yes/Age
Bronchitis	No Yes/Age	Obesity/Overweight	No Yes/Age	Depression/ Anxiety	No Yes/Age
Pneumonia	No Yes/Age	Acne	No Yes/Age	ADD	No Yes/Age
Colic	No Yes/Age	Eating Disorders	No Yes/Age	ADHD	No Yes/Age
Ear Infections	No Yes/Age	Other Illness	Age	Behavior problems	No Yes/Age
Eczema	No Yes/Age	Other Illness	Age	Bedwetting	No Yes/Age

Comments on any illnesses indicated above:

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type_____ Date ___/___/_____

Treatment _____

HOSPITALIZATIONS:

Reason for Hospitalization

Date___/___/_____

SURGERIES:

Type of Surgery

Date___/___/_____

LABS AND EXAM HISTORY:

Date of last well child check:___/___/_____ Date of last blood work:___/___/_____

Female Adolescents:

Date of Last Menses: ___/___/_____ Date of last PAP and pelvic exam: ___/___/_____

SOCIAL HISTORY

Parent's Marital Status:

□ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership

Living With: □ Both Parents □ Mother □ Father □ Grandparents □ Foster Family □ Other_____

Siblings (Indicate names and ages)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____