

GREENLAKE PRIMARY CARE PEDIATRIC PATIENT INFORMATION

Patient's Name _____

Gender: M F Social Security No. _____ - _____ - _____ (if known) Birth Date _____
First Initial Last (Mo./Day/Yr)

Who lives in the house with the child _____

Street Address where patient lives _____

Street/P.O.Box (Apt #) City State Zip

Primary Phone Contact # () Referred by _____
circle: home work cell pager other

PARENT/GUARDIAN #1 INFORMATION Relationship to patient _____

Name _____ Birth Date _____ Occupation _____

Home Address (if different from above) _____

Home Phone # () Other # ()
cell pager message other

Work Phone () Employer: _____

Primary Language spoken _____ Mother's Maiden Name _____
(if non-English)

Social Security No. _____ - _____ - _____ Insurance provided by this person? _____
(Please provide insurance card to receptionist)

PARENT/GUARDIAN #2 INFORMATION Relationship to patient _____

Name _____ Birth date _____ Occupation _____

Home Address (if different from above) _____

Home Phone (if different from above) () Other # ()
cell pager message other

Work Phone () Employer: _____

Primary Language spoken _____ Mother's Maiden Name _____
(if non-English)

Social Security No. _____ - _____ - _____ Insurance provided by this person? _____
(Please provide insurance card to receptionist)

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship to patient _____

Address _____

Home Phone # () Work # () Other # ()
City State Zip (cell, pager, message)

FAMILY INFORMATION

Sibling names and birth dates: _____

INSURANCE INFORMATION

Whose insurance plan is primary? (Parent#1 or Parent#2) _____

Any secondary/tertiary insurance not shown above? _____

Person responsible for bill _____ Address _____
(if different from above)

If the billing statement should be sent to any address other than the patient's, please fill it in here and include the relationship of the individual to whom it is to be sent. _____

Photo copies of insurance cards go here

Consent for Care of a Minor: I, _____ give permission
(Parent or Guardian)

authorize the providers and staff of Greenlake Place PC PS, Inc to examine and treat

(Patient) (Date of birth)

Insurance Release of Benefits and Information: I authorize insurance benefits for my child to be paid directly to the provider or clinic. I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my child's insurance plan. I authorize the physician/nurse practitioner or insurance company to release any information required for processing of insurance claims. This authorization is in effect until rescinded in writing.

Date: _____ Signature: _____

PATIENT NAME _____

BIRTH DATE _____

Gender M F FORM COMPLETED BY _____

DATE _____

HOUSEHOLD

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems
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Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parent, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

BIRTH HISTORY

Birth weight _____

Was the delivery: Vaginal? Cesarean? Circle one

Was the baby born at term? ____ Early? ____ Late? ____

If cesarean, why? _____

If early, how many week's gestation? _____

Did your baby have any problems right after birth? _____

Did mother have any illness or problem with her pregnancy?

Yes No Explain _____

Was initial feeding: Breast Bottle Circle one

During pregnancy, did mother

Did your baby go home with mother from the hospital?

Smoke Yes No Drink alcohol Yes No

Yes No Explain _____

Use drugs or medications Yes No

What _____ When _____

GENERAL

Do you consider your child to be in good health?

Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents?

Yes No Explain _____

Has your child had any surgery?

Yes No Explain _____

Has your child ever been hospitalized?

Yes No Explain _____

Is your child allergic to any medicines or drugs?

Yes No Explain _____

DEVELOPMENT

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or

emotional development? Yes No Explain _____

Are you concerned about your child's attention span?

Yes No Explain _____

If your child is in school: What grade? _____

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Additional comments: _____

FAMILY HISTORY

Have any family members had the following:

Deafness	Yes	No	Who	Comments
Nasal Allergies	Yes	No	Who	Comments
Asthma	Yes	No	Who	Comments
Tuberculosis	Yes	No	Who	Comments
Heart disease (before age 50)	Yes	No	Who	Comments
High blood pressure (before age 50)	Yes	No	Who	Comments
High cholesterol	Yes	No	Who	Comments
Anemia	Yes	No	Who	Comments
Bleeding disorder	Yes	No	Who	Comments
Liver disease	Yes	No	Who	Comments
Kidney disease	Yes	No	Who	Comments
Diabetes (before age 50)	Yes	No	Who	Comments
Bed-wetting (after age 10)	Yes	No	Who	Comments
Epilepsy or convulsions	Yes	No	Who	Comments
Alcohol abuse	Yes	No	Who	Comments
Drug abuse	Yes	No	Who	Comments
Mental Illness	Yes	No	Who	Comments
Mental retardation	Yes	No	Who	Comments
Immune problem, HIV, or AIDS	Yes	No	Who	Comments
Additional family history				

PAST HISTORY

Does your child have, or has he/she had:

Chickenpox	Yes	No	When
Frequent ear infections	Yes	No	Explain
Problems with ears or hearing	Yes	No	Explain
Nasal allergies	Yes	No	Explain
Problems with eyes or vision	Yes	No	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	Yes	No	Explain
Any heart problem or heart murmur	Yes	No	Explain
Anemia or bleeding problem	Yes	No	Explain
Blood transfusion	Yes	No	Explain
Frequent abdominal pain	Yes	No	Explain
Constipation requiring doctor visits	Yes	No	Explain
Bladder or kidney infection	Yes	No	Explain
Bed-wetting (after age 5)	Yes	No	Explain
(For girls) Has she started her menstrual periods?	Yes	No	Explain
(For girls) Are there problems with her periods?	Yes	No	Explain
Any chronic or recurrent skin problem (acne, eczema, etc)	Yes	No	Explain
Frequent headaches neurologic problem	Yes	No	Explain
Diabetes	Yes	No	Explain
Thyroid or other endocrine problem	Yes	No	Explain
Any other significant problem	Yes	No	Explain
Use of alcohol or drugs	Yes	No	Explain