

New Patient Registration

One form per child. Fill it in on your computer or phone and bring it with you, or print it and bring it completed. It saves about fifteen minutes at your first visit.

Before your first visit. Please also bring an insurance card, a photo ID, and your child's immunization record if you have one. If you are transferring from another practice, sign the records release as well and I will request the chart for you.

CHILD

as it appears on the insurance card

LEGAL LAST NAME

LEGAL FIRST NAME

MIDDLE

NAME YOUR CHILD GOES BY

DATE OF BIRTH

SEX ON INSURANCE

PRONOUNS, OPTIONAL

STREET ADDRESS

CITY

STATE

ZIP

SCHOOL OR DAYCARE

GRADE

RACE AND ETHNICITY, OPTIONAL

PARENTS AND GUARDIANS

PARENT OR GUARDIAN 1, FULL NAME

RELATIONSHIP TO CHILD

DATE OF BIRTH

MOBILE PHONE

OTHER PHONE

EMAIL

ADDRESS IF DIFFERENT FROM CHILD'S

PARENT OR GUARDIAN 2, FULL NAME

RELATIONSHIP TO CHILD

DATE OF BIRTH

MOBILE PHONE

OTHER PHONE

EMAIL

ADDRESS IF DIFFERENT FROM CHILD'S

CUSTODY OR COURT ORDERS I SHOULD KNOW ABOUT, AND WHO HAS AUTHORITY TO CONSENT TO CARE

New Patient Registration, continued

WHO MAY BRING YOUR CHILD IN, AND WHO I MAY TALK TO

List any adult who may bring your child to a visit and consent to routine care when you cannot be there: a grandparent, a nanny, a stepparent, a neighbor. You can add or remove people at any time by calling the office.

NAME	RELATIONSHIP	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>

NAME	RELATIONSHIP	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>

Emergency contacts, if I cannot reach you.

NAME	RELATIONSHIP	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>

NAME	RELATIONSHIP	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>

INSURANCE

If your child has no insurance right now, skip this section and tick the self-pay box.

☐ We are self-pay at the moment ☐ Coverage is pending or changing

PRIMARY INSURANCE CARRIER	MEMBER ID	GROUP NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>

POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	RELATIONSHIP TO CHILD
<input type="text"/>	<input type="text"/>	<input type="text"/>

SECONDARY INSURANCE, IF ANY	MEMBER ID	GROUP NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>

MEDICAID OR MICHILD ID, IF APPLICABLE	PRIMARY CARE PROVIDER LISTED ON THE CARD
<input type="text"/>	<input type="text"/>

PHARMACY

PHARMACY NAME	STREET AND CITY	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>

WHERE YOUR CHILD WAS SEEN BEFORE

PREVIOUS PEDIATRICIAN OR CLINIC	CITY	PHONE OR FAX
<input type="text"/>	<input type="text"/>	<input type="text"/>

DATE OF LAST WELL-CHILD VISIT	WHAT BRINGS YOU TO THIS PRACTICE, OPTIONAL
<input type="text"/>	<input type="text"/>

☐ Please request my child's records from the practice above. I have signed the records release.

New Patient Registration, continued

BIRTH AND EARLY HISTORY

newborns and young children especially

BIRTH WEIGHT

WEEKS GESTATION

HOSPITAL OF BIRTH

DELIVERY

--	--	--	--

Did your child spend time in the NICU or special care nursery?

☐ Yes

☐ No

Any jaundice needing treatment, feeding problems, or oxygen?

☐ Yes

☐ No

Did your child pass the newborn hearing and metabolic screens?

☐ Yes

☐ No

ANYTHING ABOUT THE PREGNANCY, DELIVERY OR NEWBORN PERIOD I SHOULD KNOW

--

MEDICAL HISTORY

ALLERGIES TO MEDICATIONS, FOODS, LATEX OR ANYTHING ELSE, AND WHAT HAPPENS

--

CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS, WITH DOSES

--

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY OF THESE?

☐ Asthma or wheezing

☐ Eczema

☐ Seasonal allergies

☐ ADHD

☐ Anxiety or depression

☐ Autism spectrum

☐ Speech or language delay

☐ Learning difficulty

☐ Seizures

☐ Diabetes

☐ Heart condition

☐ Kidney or urinary

☐ Reflux or bowel problems

☐ Frequent headaches

☐ Hearing problem

☐ Vision problem

☐ Sleep problems

☐ None of these

SURGERIES, HOSPITAL STAYS OR EMERGENCY VISITS, WITH ROUGH DATES

--

SPECIALISTS OR THERAPISTS YOUR CHILD SEES

--

Are your child's immunizations up to date?

☐ Yes

☐ No

Are you able to bring a copy of the immunization record?

☐ Yes

☐ No

Do you have any concerns about development, learning or behavior?

☐ Yes

☐ No

Is there anything about home, school or safety you would like to discuss privately?

☐ Yes

☐ No

New Patient Registration, continued

FAMILY HISTORY

blood relatives only

- | | | |
|---|---|---|
| ☐ Asthma | ☐ Severe allergies | ☐ Diabetes |
| ☐ Early heart disease | ☐ High cholesterol | ☐ High blood pressure |
| ☐ Depression, anxiety, bipolar | ☐ ADHD | ☐ Seizures |
| ☐ Childhood cancer | ☐ Genetic or inherited condition | ☐ Sudden death before age 50 |
| ☐ Childhood hearing loss | ☐ Kidney disease | ☐ None known |

DETAILS, AND WHO IN THE FAMILY

HOW I SHOULD REACH YOU

PREFERRED WAY TO CONTACT YOU FOR ROUTINE MATTERS

- ☐ Phone call
 ☐ Text message
 ☐ Email
 ☐ Patient portal

Standard text and email are convenient but not fully secure. You can change your mind at any time.

- ☐ You may send appointment reminders and brief non-urgent messages by text
☐ You may send appointment reminders and brief non-urgent messages by email
☐ You may leave a detailed voicemail at the numbers above

SIGNATURE

Everything above is accurate to the best of my knowledge. I will tell the office when my address, phone number or insurance changes.

PARENT OR LEGAL GUARDIAN, PRINTED NAME

RELATIONSHIP TO PATIENT

DATE

Signature

sign here if you are printing this form

OFFICE USE ONLY

<div></div>	<div></div>	<div></div>	<div></div>
Entered by	Date	Chart number	Insurance verified