Trinity Pediatrics Patient Information

*Patient Name:*____________________________

*Home Address:*____________________________

*City:*____________________________________

*State and Zip Code:*_______________________

{ } Male { } Female

Date of Birth: ___/___/___ Age:______

SS#_ _ _-_ _-_ _ _ _

*Pharmacy:*_________________________________

*Home Phone #*_____________________________

*Cell phone #*_______________________________

*Emergency Contact Name, relationship and phone #*_________________________________

____

Father's Name ________________*DOB*________

*Mother's Name*_______________*DOB*_________

*Guardian's name*_____________*DOB*_________

*Guardian's Employer*______________________

*Employer phone #*________________________

*Previous PCP*_____________________________

*Ethnic Group:*______________ *Race:*___________

*Primary Language*_________________________

How did you hear about us? _________________

Insurance Information

*Name of Primary Insurance:*_________________

*Insured ID#*________________________________

*Name of Subscriber:*_______________________

Subscriber's SS# _ _ _-_ _-_ _ _ _

Subscriber's DOB ___/____/____

*Relationship to Patient:*____________________

*Subscriber's Employer:*_____________________

*Subscriber's Work Number:*_________________

*Name of Secondary Insurance:*_______________

*Insured ID#*________________________________

*Name of Subscriber:*_______________________

Subscriber's SS# _ _ _-_ _-_ _ _ _

Subscriber's DOB ___/____/____

*Relationship to Patient:*____________________

*Subscriber's Employer:*_____________________

*Subscriber's Work Number:*_________________

Please provide copies of insurance cards and Guardian's identification at initial visit.

Below please list the names of others allowed to bring child into the office (ID must be present)

1. ___________________________________
2. ___________________________________
3. ___________________________________

______________________ _______________

Guardian Signature Date

_________________________ _______________

Witness Signature Date

Family History

Is there a history of any of the following in a blood relative of?

Please circle any that apply

- Tuberculosis
- Diabetes
- Asthma, hay fever, eczema, allergies
- Mental Disorders
- Seizures
- Hepatitis
- Heart disease, stroke, high cholesterol
- Sudden/unexplained Death
- Cancer
- Birth defects, genetic defects

Social History

How many adults live at home? ______

How many children live at home? _____

Smokers? ______ Who_______________

Pets? _____________ {indoor} or {outdoor}

Travel History? ____________________________

If so, when and where______________________

Allergies and Vaccination History

Does the patient have any allergies to the following, if so please explain?

- Foods __________________
- Medication______________
  ____
- Material (nickel, latex, etc.)___________________

Is patient up to date on vaccines { } Yes { } No

Please provide a copy of immunization records

Birth History

Vaginal Birth { } Forceps used? { }

Cesarean Section { } If so why?

____

In what hospital was the baby born?

____

Birth weight__________ Length________

Was the child full term or premature? Circle one

Where there any complications during pregnancy? If so, what?

____

____

Where there any complications during birth?

____

Where there any complications after birth? Circle

a. Jaundice
b. Antibiotic treatment
c. Rash
d. Blue spells
e. Convulsions
f. Did the baby remain in the hospital longer than the mother?

How was the baby fed? Circle

a. Breast milk
b. Formula (type) _________________

_____________________ _______________

Guardian Signature Date

________________________ ______________

Witness Signature Date

Developmental History

At what age did the child do the following?

a. Hold head up ____
b. Roll over ____
c. Sit unsupported ____
d. Stand alone ____
e. Walk ____
f. Talk ____
g. Toilet train ____
h. Feed him/herself ____
i. Dress him/herself ____
j. Any concerns with speech ____

Past Medical History

Has the child had any of the following? Please circle

- Chicken pox
- Measles
- German measles
- Meningitis
- Convulsions
- Contusions
- Fractures
- Poison ingestion
- Blood transfusions
- Blood disease: anemia, sickle cell, Thalassemia
- Asthma
- Kidney disease
- Eczema or other skin conditions
- Multiple ear infections
- Heart disease
- Abdominal pain
- Thyroid disease
- Headache/Migraine
- Problems with hearing or vision
- Constipation or frequent diarrhea
- Any other serious illness________________________

Has the patient had any operations? If so please list

____
____

Has the patient had any hospitalizations? If so, please list

____
____

Current medications

Is your child currently taking any medications, vitamins, or herbs? If so please list them below

Medications *Strength or dose* *how often*

____
____
____
____
____
____
____
____
____
____
____

______________________ _______________
Guardian Signature Date

_________________________ _______________
Witness Signature Date