PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: ______________________ MOTHER'S NAME: ______________________
LAST FIRST MIDDLE LAST FIRST MIDDLE

CASE NUMBER: ______________________ FATHER'S NAME: ______________________
LAST FIRST MIDDLE

ADDRESS: ______________ CITY/TOWN: ______________ STATE: ______ ZIP: ______

HOME PHONE: __________ MOTHER'S WORK PHONE: __________ FATHER'S WORK PHONE: __________

BIRTH DATE: ___/___/___ AGE: _____ BIRTH WEIGHT: __________ CURRENT WEIGHT: __________

SEX: ______ NO. OF SIBLINGS: ______ BIRTH LENGTH: __________ CURRENT LENGTH: __________

TYPE OF BIRTH: NORMAL VAGINAL: ___ FORCEPS: ___ BREECH: ___ CESARIAN: ___

HOME: __________ BIRTHING CENTER: __________ HOSPITAL: __________

PROBLEMS DURING PREGNANCY: ______________________________

PROBLEMS DURING LABOR/DELIVERY: ______________________________

APGAR SORES: ______ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW) ___ CYANOSIS (BLUE) ___

CONGENITAL ANOMALIES / DEFECTS: ______________________________

INFANT FEEDING: BREAST: __________ BOTTLE: __________ FORMULA: __________

NO. OF HOURS OF SLEEP PER NIGHT: ______ QUALITY OF SLEEP: GOOD ______ FAIR ______ POOR ______

OBSTETRICIAN / MIDWIFE: ______________________________
NAME LOCATED AT

PEDIATRICIAN / FAMILY MD: ______________________________
NAME LOCATED AT

DATE OF LAST VISIT TO MD: __________ PURPOSE: ______________________________

IMMUNIZATION HISTORY: ______________________________

PURPOSE OF THIS APPOINTMENT: ______________________________

HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS: ______________________________

DESCRIBE: ______________________________

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD.

SIGNED: ______________________ WITNESSED: ______________________ DATE: ______

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

SIGNATURE: ______________________________ DATE: ______

SURGERY: ______________________________

MEDICATIONS: ______________________________

ACCIDENTS: ______________________________

FAMILY HISTORY: ______________________________