Pediatric Staff PLLC

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Phone: 248 281-3215 / Fax: 248 569-9150

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ Policy ID#: _____

Group #: _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____

Insurance Carrier: _____ Policy ID#: _____

Group #: _____

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ Policy ID#: _____

Group #: _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____

Insurance Carrier: _____ Policy ID#: _____

Group #: _____

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White/ Unknown

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ Policy ID#: _____

Group #: _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____

Insurance Carrier: _____ Policy ID#: _____

Group #: _____

Mailing Address: _____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____

Who lives at this household? _____

(Please note, this information is being requested to improve intake of your child's Social History.)

Contact Information

Contact 1: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number:

_____ Is this a cell phone? Yes / No and their Address:

_____

Relation to Patient: _____ Biological Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email or Work email

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Contact 2: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number: _____

Is this a cell phone? Yes / No and their Address: _____

Relation to Patient: _____ Biological Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ Phone: (___) _____ - _____

2: _____ Relationship _____ Phone: (___) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No

If no, list who may have access

_____

If parents are divorced or separated please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Interval History Information

Completed by: _____ Date Completed: _____

Allergy / Reaction Information

Medication Allergies: No: _____ Yes: ____ (List below)

1:

_____

(Medication) (Reaction)

2:

_____

(Medication) (Reaction)

Non-Medication Allergies: No: ___ Yes: _____

Vaccine Reactions: No: ___ Yes: _____

Current Medications

1.

_____

(Medication) (Dose) (Date Started)

2.

_____

(Medication) (Dose) (Date Started)

3.

_____

(Medication) (Dose) (Date Started)

4.

_____

(Medication) (Dose) (Date Started)

Problem List

1.

_____

(Diagnosis) (Date)

Details:

2.

_____

(Diagnosis) (Date)

Details:

3.

_____

(Diagnosis) (Date)

Details:

Pertinent Past Medical History

(Please provide details including date)

___Serious Injuries Please list: _____

___Surgeries Please list: _____

___Hospitalizations Please list: _____

Pertinent Family Medical History:

_____

Pertinent Social History:

_____