CHILDS

Registration / History

Date _____

Patient's Name _____ D.O.B _____

Father's Name _____ Cell Phone _____

Mother's Name _____ Cell Phone _____

Street Address _____ Phone _____

City _____ State _____ Zip _____

Father Employed by _____ Phone _____

Business Address _____

Present Position _____ How long held _____

Mother Employed by _____ Phone _____

Business Address _____

Present Position _____ How long held _____

Parent's Driver's License Number _____

In case of emergency, who should be notified _____

Who will pay this account _____

Father's Social Security Number _____ Birthdate _____

Mother's Social Security Number _____ Birthdate _____

If Military, Sponsor's Social Security Number _____

Do you have insurance that may cover any part of our professional services — Yes _____ No _____

If so, name of primary company _____ Policy No. _____

Social Security No. of Policy Holder _____ Group No. _____

Do you have any other insurance _____ Yes _____ No _____

If so, name of secondary company _____ Policy No. _____

Social Security No. of Policy Holder _____ Group No. _____

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage)

Who may we thank for referring you _____

ATTENTION MILITARY: Permanent home of record, please. _____

Street Address _____

City _____ State _____ Zip _____

PLEASE COMPLETE REVERSE SIDE

CHILD

Date of last MEDICAL examination _____ Current Age ____

For what _____

Have you been hospitalized in last 5 years ____ if so, for what _____

_____

Do you have or have you had:	Yes	No		Yes	No
Anemia	____	____	Asthma	____	____
Diabetes	____	____	Are you allergic to:		
Epilepsy	____	____	Penicillin	____	____
Hepatitis	____	____	Local Anesthetic	____	____
Rheumatic fever	____	____	Latex	____	____
Heart murmur	____	____	Medication or Drugs	____	____
Abnormal heart condition	____	____	Peanuts	____	____
Abnormal bleeding from a cut	____	____	Women: Are you pregnant	____	____
HIV / AIDS	____	____			
Abnormal Blood Pressure	____	____			

If allergic to medications or drugs, indicate which ones _____

Are you taking any medication now ____ If so, for what _____

So we can serve you better, please list any disability you may have. _____

_____

Other physical conditions of which we should be aware: _____

_____

Name of your physician _____ Phone _____

Are you receiving care now ____ If so, nature of care _____

Are you now receiving other health care Yes ☐ No ☐

If so, nature of care	Name of doctor	Phone

May we request your dental records Yes ☐ No ☐

To whom should we address request _____

_____

This information was given by _____