Patient Name: _____
MRN: _____
Birthdate: _____
Age: _____ ☐M ☐F

Household Information

Home Address _____
City, State, Zip _____ Home Phone _____

Mother: Name _____ Birthdate _____ Work Phone _____ Cell _____
Employer _____ Occupation _____
Email address: _____ ☐ Use this email for appointment confirmations

Father: Name _____ Birthdate _____ Work Phone _____ Cell _____
Employer _____ Occupation _____
Email address: _____ ☐ Use this email for appointment confirmations

Please list all those living in the child's home

Name	Relationship to child	Birthdate	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live.

_____
_____

Does anyone smoke? _____ Any pet? _____ ☐ Inside ☐ Outside

Does child attend daycare? _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

_____

If one or both parents are not living in the home, how often does child see the parent/parents not in the home? _____

_____

IN CASE OF EMERGENCY, NOTIFY: (Other than parents)
Name _____ Home phone _____ Work phone _____
Relationship to patient _____

Name _____ Home phone _____ Work phone _____
Relationship to patient _____

Name _____ Home phone _____ Work phone _____
Relationship to patient _____

PLEASE LIST THE PERSON(S) THAT YOU AUTHORIZE TO ACCOMPANY AND GIVE CONSENT FOR TREATMENT TO THE CHILD AT APPOINTMENT TIME, OTHER THAN A PARENT
Name _____ Phone _____ Relationship to Child _____
Name _____ Phone _____ Relationship to Child _____
Name _____ Phone _____ Relationship to Child _____

Signature of Parent/Legal Guardian of Minor _____ Date _____
Relationship to Patient/Minor _____ Witness by _____

Patient Name: _____
MRN: _____
Birthdate: _____
Age: _____ ☐M ☐F

Family History

Have any family members (including natural parents, grandparents, aunts, uncles, sisters or brothers) had the following:

Deafness	☐Y ☐N	Who _____	Comments _____	
Nasal allergies	☐Y ☐N	Who _____	Comments _____	
Asthma	☐Y ☐N	Who _____	Comments _____	
Tuberculosis	☐Y ☐N	Who _____	Comments _____	
Heart disease (before 50 yrs old)	☐Y ☐N	Who _____	Comments _____	
High blood pressure (before 50 yrs old)	☐Y ☐N	Who _____	Comments _____	
High cholesterol	☐Y ☐N	Who _____	Comments _____	
Anemia	☐Y ☐N	Who _____	Comments _____	
Bleeding disorders	☐Y ☐N	Who _____	Comments _____	
Liver disease	☐Y ☐N	Who _____	Comments _____	
Kidney disease	☐Y ☐N	Who _____	Comments _____	
Diabetes (before 50 yrs old)	☐Y ☐N	Who _____	Comments _____	
Bedwetting (after 10 yrs old)	☐Y ☐N	Who _____	Comments _____	
Epilepsy or convulsions	☐Y ☐N	Who _____	Comments _____	
Alcohol abuse	☐Y ☐N	Who _____	Comments _____	
Drug abuse	☐Y ☐N	Who _____	Comments _____	
Mental illness	☐Y ☐N	Who _____	Comments _____	
Mental retardation	☐Y ☐N	Who _____	Comments _____	
Learning or attention problems	☐Y ☐N	Who _____	Comments _____	
Immune problems, HIV, or AIDS	☐Y ☐N	Who _____	Comments _____	

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐Y ☐N	When _____	
Frequent ear infections	☐Y ☐N	Explain _____	
Problems with ears or hearing	☐Y ☐N	Explain _____	
Nasal allergies	☐Y ☐N	Explain _____	
Problems with eyes or vision	☐Y ☐N	Explain _____	
Asthma, bronchitis, bronchiolitis	☐Y ☐N	Explain _____	
Pneumonia	☐Y ☐N	Explain _____	
Any heart problem or heart murmur	☐Y ☐N	Explain _____	
Anemia or bleeding problem	☐Y ☐N	Explain _____	
Blood transfusion	☐Y ☐N	Explain _____	
Frequent abdominal pain	☐Y ☐N	Explain _____	
Constipation requiring doctor visits	☐Y ☐N	Explain _____	
Bladder or kidney infection	☐Y ☐N	Explain _____	
Bedwetting (after 5 years old)	☐Y ☐N	Explain _____	
For girls, start of her menstrual periods?	☐Y ☐N	When _____	
For girls, any problem with her periods?	☐Y ☐N	Explain _____	
Any chronic or recurrent skin problem (acne, eczema, etc)	☐Y ☐N	Explain _____	
Frequent headaches	☐Y ☐N	Explain _____	
Convulsions or other neurologic problem	☐Y ☐N	Explain _____	
Diabetes	☐Y ☐N	Explain _____	
Thyroid or other endocrine problem	☐Y ☐N	Explain _____	
Use of alcohol or drugs	☐Y ☐N	Explain _____	
Learning or attention problems	☐Y ☐N	Explain _____	
Any other chronic problem	☐Y ☐N	Explain _____	

Name _____ Birth Date _____ Date First Seen _____

Race _____ Sex _____ Insurance _____

Hospital _____ Address _____ Phone _____

Obstetrician _____ Address _____ Phone _____

Referred by _____

Father's Name _____ Address _____ Phone _____

Mother's Name _____ Address _____ Phone _____

ALLERGIES (✓)

	Age	Health	Environmental/Food	Type of Allergy
Mother				
Father				
Sibling				
Sibling				

FAMILY HISTORY

Miscarriage _____ Month _____ Cause _____

Tuberculosis _____ TBC Contacts _____

Diabetes _____ Convulsive Disease _____

Mother's Blood Type _____ RH _____

Baby's Blood Type _____

OTHER

BIRTH AND DEVELOPMENT

Term _____ Delivery _____ Birth Weight _____

Condition at Birth _____ Apgar Score _____

Condition 1st Week _____

Feeding _____ Cyanosis _____

Convulsions _____ Jaundice _____

Sat Up _____ Stood _____ Walked _____ Words _____

Short Sentences _____ First Teeth _____ Bladder _____ Bowel _____

FEEDING HISTORY

Breast _____ Formula _____ Vitamins _____

Primary Drinking Water Supply: ☐ Well ☐ City/Municipal ☐ Bottle Area Water Fluoride Level: ☐ Inadequate ☐ Adequate ☐ Unknown

Fluoride Supplements: *Topical* ☐ Rinse ☐ Gel ☐ Paste *Systemic* ☐ Vitamin/Fluoride Supplement ☐ Fluoride-Only Supplement

Soft Food _____ Present Diet _____ Feeding Habits _____

Appetite _____ Likes _____ Dislikes _____

Vomiting _____ Stools _____ Sensitivity _____ Hives _____

IMMUNIZATION AND SKIN TESTING

	DATE	DATE	DATE	DATE	DATE	DATE
DTaP						
IPV						
HIB						
VARICELLA						
MMR						
PREVNAR						
HEPATITIS A						
HEPATITIS B						
TUBERCULIN						
DT						
OTHER						

ILLNESSES

Pertussis

Measles

Rubella

Mumps

Chickenpox

Scarlet Fever

Diphtheria

Operations

T. and A.

Allergy

Appendix

Glands

Rheumatic Fever

Otitis

Colds

Tonsilitis

Convulsions

Constipation

Diarrhea

Asthma

AUTHORIZATION TO CONTACT PATIENT AND RECORD OF DISCLOSURES

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone: _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave a message with call-back number only.

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to: _____

☐ Work Telephone: _____
- ☐ OK to leave a message with detailed information
- ☐ Leave a message with call-back number only

☐ Other: _____

_____ _____
(Patient's Signature) (Date)

_____ _____
(Print Name) (Date)

Healthcare entities must keep records of PHI disclosures. The information provided below, if completed properly, will constitute an adequate record.

NOTE: ***Uses and disclosures for TPO may be permitted without prior consent in an emergency.***

DATE	DISCLOSED TO WHOM ADDRESS OR FAX NUMBER	DESCRIPTION OF DISCLOSURE/PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED	(1)	(2)

(1) CHECK THIS BOX IF DISCLOSURE IS AUTHORIZED
(2) ENTER HOW DISCLOSURE WAS MADE: F= FAX: P= PHONE: E= EMAIL: M= MAIL: O= OTHER

COMMENTS: _____