PATIENT INFORMATION

Child 1: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Child 2: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Child 3: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Preferred Pharmacy: _____ **Pharmacy Location:** _____

Insurance Information:

Primary Policy
Insurance Carrier: _____ Insurance ID #: _____ Group #: _____
Name of Policy Holder: _____ DOB of Policy Holder: _____

Secondary Policy
Insurance Carrier: _____ Insurance ID #: _____ Group #: _____
Name of Policy Holder: _____ DOB of Policy Holder: _____

Mother/Guardian Info

First Name: _____ **Middle Name:**_____ **Last Name:** _____ **DOB:** _____

Employer/Occupation: _____ **SSN:** _____

Primary Phone (**Circle**: Home/Cell) _____ **Secondary Phone** (**Circl**e: Home/Cell/Work) _____

Home Address: _____

E-mail: _____ **Authorized to have access to patient's records electronically?** ☐ **Yes** ☐ **No**
What is your preferred method of contact for appointment reminders? Cell Phone / Home Phone/ E-mail

Father/Guardian Info

First Name: _____ **Middle Name:**_____ **Last Name:** _____ **DOB:** _____

Employer/Occupation: _____ **SSN:** _____

Primary Phone (**Circle**: Home/Cell) _____ **Secondary Phone** (**Circl**e: Home/Cell/Work) _____

Home Address: _____

E-mail: _____ **Authorized to have access to patient's records electronically?** ☐ **Yes** ☐ **No**
What is your preferred method of contact for appointment reminders? Cell Phone / Home Phone/ E-mail

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Responsible Party Information: The responsible party is the person that will be receiving the billing statements. This person is also financially responsible for the patient's medical bills. Copays and balance payments are expected at time of service, regardless of custodial agreements.

First Name: _____ Middle Name:_____ Last Name: _____ DOB: _____

Home Address: _____
Street City State Zip Code

Phone Number: _____ Relationship to Patient: _____

Alternate Contact Information: Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. Indicated below are the names of any person(s) to whom you allow disclosure of health information related to your child and authorize to oversee patient care.

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____

Phone Number: _____ Relationship to Patient: _____

Notify In Case Of Emergency (Not A Parent/Guardian)

Name_____Relationship_____ Phone_____

Name_____Relationship_____ Phone_____

Separated/Divorced Families

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.

_____

Authorization of Treatment and Assignment of Benefits

I authorize Northwest Pediatrics Inc., to treat my child. I have been presented with a copy of the Notice of Privacy Practice detailing how my child's health information may be used and disclosed as permitted under the federal and state law and outlining my rights regarding my child's health information. I also acknowledge that I have been presented with a copy of Northwest Pediatrics Office Policies.

Signature of Parent or Legal Guardian_____

Relationship to Child_____ Date_____

Person Completing Form

Printed Name: _____ Signature: _____ Date: _____

Family History

You may use one form for all children that share the same biological family members listed below. For additional forms, please see the front desk.

Please check:

☐ *This family history applies to* ***all*** *children listed on reverse side*

or

☐ *This family history applies to the following children:* _____

Northwest Pediatrics

Please circle alive or deceased for each family member and check all		Asthma	Heart attack before age 50	Heart Disease	High Blood Pressure	High Cholesterol	Diabetes	Kidney Disease	Seizure Disorder	Thyroid Disease	Liver Disease	ADD/ ADHD	Cancer	Mental Illness	Substance Use
Father	alive deceased												Type _____	Type _____	Type _____
Mother	alive deceased												Type _____	Type _____	Type _____
Father's Father	alive deceased												Type _____	Type _____	Type _____
Father's Mother	alive deceased												Type _____	Type _____	Type _____
Mother's Father	alive deceased												Type _____	Type _____	Type _____
Mother's Mother	alive deceased												Type _____	Type _____	Type _____
Father's Brother(s)	alive deceased												Type _____	Type _____	Type _____
Father's Sister(s)	alive deceased												Type _____	Type _____	Type _____
Mother's Brother(s)	alive deceased												Type _____	Type _____	Type _____
Mother's Sister(s)	alive deceased												Type _____	Type _____	Type _____

Other: _____

Signature: _____ **Relationship To Child**: _____ **Date:** _____

Past Medical History

1) **Who lives in the house with the children listed below?** _____

2) **Are there smokers in the home?** ☐ **No** ☐ **Yes** **If yes, please circle: Inside Outside Car**

3) **Are there guns in the home?** ☐ **No** ☐ **Yes** **If yes, are they locked?** ☐ **No** ☐ **Yes**

4) **Within the last 12 months, have you worried whether food would run out before you got money to buy more?** ☐ **No** ☐ **Yes**

5) **Do you ever need help when reading instructions or other written material from your doctor or pharmacy?** ☐ **No** ☐ **Yes**

Child 1	**Child 2**	**Child 3**
Full Name: _____	**Full Name:** _____	**Full Name:** _____
☐ ADD/ADHD	☐ ADD/ADHD	☐ ADD/ADHD
☐ Abdominal Pain/GER	☐ Abdominal Pain/GER	☐ Abdominal Pain/GER
☐ Allergies	☐ Allergies	☐ Allergies
☐ Anemia or bleeding problem	☐ Anemia or bleeding problem	☐ Anemia or bleeding problem
☐ Anxiety	☐ Anxiety	☐ Anxiety
☐ Asthma	☐ Asthma	☐ Asthma
☐ Autism	☐ Autism	☐ Autism
☐ Bed-wetting (after 5 years of age)	☐ Bed-wetting (after 5 years of age)	☐ Bed-wetting (after 5 years of age)
☐ Bladder or kidney infection	☐ Bladder or kidney infection	☐ Bladder or kidney infection
☐ Blood Transfusion	☐ Blood Transfusion	☐ Blood Transfusion
☐ Cancer	☐ Cancer	☐ Cancer
☐ Concussion	☐ Concussion	☐ Concussion
☐ Constipation	☐ Constipation	☐ Constipation
☐ Chronic skin problems	☐ Chronic skin problems	☐ Chronic skin problems
☐ Developmental Delays	☐ Developmental Delays	☐ Developmental Delays
☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Eating Disorder	☐ Eating Disorder	☐ Eating Disorder
☐ Eye conditions	☐ Eye conditions	☐ Eye conditions
☐ Frequent ear infections	☐ Frequent ear infections	☐ Frequent ear infections
☐ Frequent headaches	☐ Frequent headaches	☐ Frequent headaches
☐ Hearing Impairment	☐ Hearing Impairment	☐ Hearing Impairment
☐ Heart problems or heart murmur	☐ Heart problems or heart murmur	☐ Heart problems or heart murmur
☐ Kidney Disease/Urologic Concerns	☐ Kidney Disease/Urologic concerns	☐ Kidney Disease/Urologic concerns
☐ Metabolic/Genetic disorder	☐ Metabolic/Genetic disorder	☐ Metabolic/Genetic disorder
☐ Orthopedic problems	☐ Orthopedic problems	☐ Orthopedic problems
☐ Pneumonia	☐ Pneumonia	☐ Pneumonia
☐ Recurrent urinary tract infections	☐ Recurrent urinary tract infections	☐ Recurrent urinary tract infections
☐ Serious injuries or accidents	☐ Serious injuries or accidents	☐ Serious injuries or accidents
☐ Seizures	☐ Seizures	☐ Seizures
☐ Thyroid problems	☐ Thyroid problems	☐ Thyroid problems
☐ Use of alcohol or drugs	☐ Use of alcohol or drugs	☐ Use of alcohol or drugs
☐ Visual Impairment	☐ Visual Impairment	☐ Visual Impairment
Other:	**Other:**	**Other:**
_____	_____	_____
Surgeries/Dates: ☐ **None**	**Surgeries/Dates:** ☐ **None**	**Surgeries/Dates:** ☐ **None**
_____	_____	_____
_____	_____	_____
Hospitalizations/Dates: ☐ **None**	**Hospitalizations/Dates:** ☐ **None**	**Hospitalizations/Dates:** ☐ **None**
_____	_____	_____
_____	_____	_____
Food/Medication Allergies: ☐ **None**	**Food/Medication Allergies:** ☐ **None**	**Food/Medication Allergies:** ☐ **None**
_____	_____	_____