Patient Registration

Please fill out this form COMPLETELY and print LEGIBLY.

Patient/Child

Child's SS# : ________________________ Address: ________________________
Last Name: ________________________ City: ________________ State: ________
First Name: ________________________ Zip: __________ Phone: ________________
Nickname: ________________________ Date of Birth: ______________ Sex: ________

Parent 1 Name: ________________________ DOB: __________ SS#: ____________
Relationship to Patient: ______________ (i.e., mother, father, foster, legal guardian, etc.)
Parent 1 Address: ________________________
Employer's Name: ________________________ Occupation: ________________
Phone #: Home: ______________ Cell: ______________ Work: ______________
Step Parent? NO YES *(If yes, please provide name and phone number)*
Step Parent Name: ________________ Phone #: ________

Parent 2 Name: ________________________ DOB: __________ SS#: ____________
Relationship to Patient: ______________ (i.e., mother, father, foster, legal guardian, etc.)
Parent 2 Address: ________________________
Employer's Name: ________________________ Occupation: ________________
Phone #: Home: ______________ Cell: ______________ Work: ______________
Step Parent? NO YES *(If yes, please provide name and phone number)*
Step Parent Name: ________________ Phone #: ________

Patient Lives With:

Name: ________________________ Phone # : ________________
Address: ________________________
City: ______________State: ________ Zip: __________
Relationship to patient: ______________________

Primary Insurance Information/Responsible Party

Insurance Company: ________________________ Responsible Party SS#: ________________
Last Name: ________________________ Address: ________________________
First Name: ________________________ City: ________________ State: ______
Date of Birth: ________________ Zip: __________ Phone#: ________________
Employer: ________________________
Employer Address: ________________________
City: ____________ State: ____ Zip: ________ Phone #: ____________

Nearest Relative or Friend (NOT living with you/not listed above)

Name: ________________________ Phone # : ________________
Address: ________________________
City: ______________State: ________ Zip: __________
Relationship to patient: ______________________

PLEASE READ AND SIGN THE FOLLOWING STATEMENT: I authorize my family insurance benefits to be paid directly to Arvada Pediatrics and the release of any pertinent medical information. I understand that I am financially responsible for any services not covered by my insurance, as verified by the information above.

Signature: ________________________ Date: ______________

New Patient Information

(Information will be strictly confidential)

Child's full legal name: ____ Date of Birth: ___________________

Child's medical history:

1 Any allergies to medicines? (list) ____

2 Other allergies? (list) ____

3 Hospitalizations? (list reason and age):

____

____

4 Surgeries? (list reason and age):

____

____

5 Check any of the following that apply:

____ asthma	____ high blood pressure
____behavioral problems	____ kidney disease
____ cancer	____ psychiatric illness
____ convulsions	____ recurrent ear infections
____ diabetes	____ urinary tract infections

Other chronic problems: ____

6 Was the child born on time (within 3 weeks)? ____ yes ____no

If NO, how early? _____________

7 Birth weight: ____________________

8 Problems while in the newborn nursery? ____ yes ____no

If YES, specify: ____

9 Problems as an infant? ____ yes ____no

IF YES, specify: ____

10 Has the child's development seemed normal? ____ yes ____no

If NO, specify: ____

FAMILY AND SOCIAL HISTORY

1. Parents are: ____married ____ single ____separated ____deceased
____ divorced and single ____ divorced and remarried
2. List names and dates of birth of other children living at home. (includes last names if different and note if from previous marriage or adopted):
A. ______________________________________ B. ______________________________________
C. ______________________________________ D. ______________________________________
E. ______________________________________ F. ______________________________________
3. List names and date of birth of other children NOT living at home (includes last names if different and note if from previous marriage or adopted):
A. ______________________________________ B. ______________________________________
C. ______________________________________ D. ______________________________________
E. ______________________________________ F. ______________________________________
4. Adults, other than parents, living at home. (Include relationship, if any).
A. ______________________________________ B. ______________________________________

FAMILY'S MEDICAL HISTORY:

1. Check any of the following that apply (to the parents):

____anorexia	____ diabetes
____ arthritis	____ drinking/drug problems
____ asthma	____ heart disease
____ bleeding problems	____ high blood pressure
____ blood clots	____ kidney disease
____ cancer	____ psychiatric illness
____ convulsions	____ neurological disease

   Other chronic/debilitating diseases: ____

2. Check any of the following that apply (to other children):

____anorexia	____ diabetes
____ arthritis	____ drinking/drug problems
____ asthma	____ heart disease
____ bleeding problems	____ high blood pressure
____ blood clots	____ kidney disease
____ cancer	____ psychiatric illness
____ convulsions	____ neurological disease

   Other chronic/debilitating diseases: ____

3. Extended family:

   Genetic diseases (diseases which run in the family): ____________________________________

4. Check any of the following that apply (in males under 60 or in any female relative):

____heart attack	____ stroke
____ bypass surgery	____ angina

5. Close friends and family members:

   Does anyone currently have a very serious or terminal illness? ____ yes ____ no

   If YES, specify: ____

   Any recent deaths? ____yes ____ no

   If YES, who? ____

PREVENTATIVE HISTORY:

1. Is your child using a car seat, booster seat, seat belt, or none of these? ________________________
2. Do you have a thermometer at home? ____ yes ____ no
3. Do you know how to take a rectal temperature? ____ yes ____ no
4. Do you have Acetaminophen (Tylenol) or Ibuprofen (Motrin, Advil) at home? ____ yes ____ no
5. Cigarette, cigar or pipe smokers (check all that apply):

   ____ mom ____ dad ____ Other: ______________________

6. Marijuana use in the home (check all that apply):

   ____ mom ____ dad ____ Other: ______________________

7. Guns in the home? ____ yes ____ no

   If so, are they locked in a gun safe? ____ yes ____ no