NEW PEDIATRIC INTAKE FORM

DATE___________

Child's Name __________________________________Date of Birth_______ Age______

Address____

____

Home Phone Number_____________________

With whom does this child live with (circle)?

Mother Father Both Other (indicate relationship)____________________________

Insurance Company ____

Name of Insured ____

Policy # _____________________________Group #_________________________________

Who Should we contact in case of Emergency?

Name___________________________________ Relationship________________________

Address____

Phone____

Who has permission to bring in your child to my office for treatment?

Name	Relationship to child	Phone#
____________________	__________________________	____________________
____________________	__________________________	____________________
____________________	__________________________	____________________

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What are your Top Three Health Concerns for your child?

1) ____

2) ____

3) ____

Where was your child Born?

_____ home _____ hospital _____ birth center

Was Your Child Breastfed? ________ How Long? ______________

HEALTH HISTORY

Has Your Child had any of the following conditionsin the past or currently? C=currently P=past

______Asthma

______Ear Infection

______Eczema

______Rashes

______ Allergies

______Chicken Pox

______ Bladder Infection

_______ Colic

______Broncitis

______ Strep Throat

______Constipation

What Vaccines Has your Child Had?

_______DPT

_______DT

_______Hepatitis

_______Tetanus only

_______HIB

_______Polio

_______MMR

_______Chicken Pox