PATIENT REGISTRATION

Patient Name ____
First Middle Last

Sex _____ Date of Birth ____ / ____ / ____ Ethnicity:_____________ Race:_______________

Parent 1 ____
First Middle Last

Social Security # ______ - _____ - ______ Date of Birth ____ / ____ / ____

Home Address ________________________________ City _______________ State ____ Zip _______

Home Phone (_____) ____________Cell Phone (_____) __________Email _______________________

Employer ____________________________________ Work Number (_____) ____________________

☐ Single ☐ Divorced ☐ Separated ☐Married

Parent 2 ____
First Middle Last

Social Security # ______ - _____ - ______ Date of Birth ____ / ____ / ____

Home Address ________________________________ City _______________ State ____ Zip _______

Home Phone (_____) ____________Cell Phone (_____) __________Email _______________________

Employer ____________________________________ Work Number (_____) ____________________

☐ Single ☐ Divorced ☐ Separated ☐ Married

I certify that all information contained in this form is true and correct to the best of my knowledge.Child Plus Pediatrics has my permission to examine and administer treatment as deemed necessary to my child. Co-pays, deductibles, and all co-insurance payments will be expected at time of service.

Signature: ____ Date: __________________*

GUARANTOR/RESPONSIBLE PARTY INFORMATION

☐ Mother as listed above ☐ Father as listed above ☐ Other individual as listed below

Guarantor Name ____
First Middle Last

Relationship _________________________ Sex _____ Daytime Phone (_____) ___________________

Address _____________________________________ City _______________ State ____ Zip _______

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604 E. Bailey Boswell, Suite 140, Saginaw TX 76131
Phone 817-484-6610 Fax 817-570-0181

MEDICAL HISTORY

Birth History

Birthplace ____
Facility Name City State

Birth Weight _______________ Birth Length _______________

Normal Pregnancy ☐ Yes ☐ No, explain ____________________________________

Full Term Pregnancy ☐ Yes ☐ No, explain ____________________________________

Normal Delivery ☐ Yes ☐ No, explain ____________________________________

Normal Nursing ☐ Yes ☐ No, explain ____________________________________

Baby Feeding ☐ Nursed ☐ Bottle Fed ☐ Both

Past Medical History

Has your child had any unusual problems with the following?

Head ☐ No ☐ Yes, explain ______________ Eyes ☐ No ☐ Yes, explain ______________

Kidney ☐ No ☐ Yes, explain ______________ Chest/Heart/Lungs ☐ No ☐ Yes, explain ____________

Blood ☐ No ☐ Yes, explain ______________ Ear/Nose/Throat ☐ No ☐ Yes, explain ____________

Bladder ☐ No ☐ Yes, explain ______________ Bones/Muscles/Joints ☐ No ☐ Yes, explain _________

Skin ☐ No ☐ Yes, explain ______________ Stomach ☐ No ☐ Yes, explain _______________

Does your child have a history of any of the following?

Sleeping Problems ☐ No ☐ Yes, explain ____________________________________

Bedwetting ☐ No ☐ Yes, explain ____________________________________

Weight or Height ☐ No ☐ Yes, explain ____________________________________

Nightmares ☐ No ☐ Yes, explain ____________________________________

Eating Problems ☐ No ☐ Yes, explain ____________________________________

Colic Problems ☐ No ☐ Yes, explain ____________________________________

Special Diet ☐ No ☐ Yes, explain ____________________________________

Taking Vitamins ☐ No ☐ Yes, explain ____________________________________

Taking Fluoride ☐ No ☐ Yes, explain ____________________________________

Ever had any of the following contagious diseases?

Measles ☐ No ☐ Yes Mumps ☐ No ☐ Yes Chickenpox ☐ No ☐ Yes

Scarlet Fever ☐ No ☐ Yes Rubella ☐ No ☐ Yes Other ☐ No ☐ Yes

Medications

Does your child currently take any medications? ☐ No ☐ Yes, list them ____________________

Hospitalizations

____
Date Diagnosis Where

____
Date Diagnosis Where

____
Date Diagnosis Where

Surgery

____

Date Diagnosis Where

Date Diagnosis Where

Date Diagnosis Where

Serious Injuries

Date Diagnosis Where

Date Diagnosis Where

Date Diagnosis Where

Allergic Reactions

Please list any allergic reactions your child may have had including drug reactions, asthma, hives, eczema, hay fever.

Family History

Mother ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other

Father ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other

☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other

☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling

Does your child have any family members with the following problems?

☐ Diabetes ☐ Allergies ☐ Convulsions ☐ Heart Disease ☐ TB ☐ Cancer ☐ Auto Immune Deficiency

Social History

Who has legal custody of the patient? ____

Name Relationship to patient

Please list the name and relationship of all individuals who live with the patient.

Name Relationship Name Relationship

Name Relationship Name Relationship

Name Relationship Name Relationship

Does anyone living with the patient use any of the following?

Tobacco ☐ No ☐ Yes, who ___________

Do you have any special comments or concerns about your child?

I hereby authorize Child Plus Pediatrics to secure a copy of my child medication history ☐ No ☐ Yes

How did you find out about Dr. Davis and Child Plus Pediatrics?

Marketing Activities	*Please be as descriptive as possible as it track our marketing efforts*	
Personal Referral		
Practice Website		
Referral from School		
Advertising Banner		
Magazine		

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