Pediatrics & Endocrinology

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PLEASE PRINT CLEARLY

PATIENT INFORMATION:

NAME: _____ **BIRTHDATE:** _____ **AGE:** _____
(Last Name) (First Name) (Middle Initial)

SEX: Circle: Female Male: SS#: _____
Marital Status: Married Single Other

ADDRESS_____**APT NO**_____**TELEPHONE**_____

CITY: _____STATE_____ZIP CODE_____

EMPLOYER_____WORK TELEPHONE_____

STUDENT: YES ____NO____ FULL-TIME____ PART-TIME____NAME OF SCHOOL_____

NAME OF SPOUSE_____WORK TELEPHONE_____

INSURANCE INFORMATION: Please present your insurance cards to the Receptionist.

PRIMARY _____NAME OF INSURED PARTY_____

SECONDARY_____NAME OF INSURED PARTY_____

OTHER COVERAGE_____NAME OF INSURED PARTY_____

IS TODAY'S VISITING THE RESULT OF AUTO ACCIDENT? _____WORK INJURY____DATE_____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE RESPONSIBLE PARTY

NAME_____**RELATIONSHIP TO PATIENT**_____

SOCIAL SECURITY NUMBER _____-_____-_____

ADDRESS_____APT NO_____ TELEPHONE _____

CITY_____STATE_____ZIP CODE_____BIRTHDATE_____

EMPLOYER_____WORK TELEPHONE_____

NAME OF SPOUSE_____SS# _____BIRTHDATE_____

EMPLOYER_____WORK TELEPHONE_____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

EMERGENCY CONTACT (person not living with you)_____RELATIONSHIP_____

ADDRESS_____TELEPHONE_____

SIGNATURE OF RESPONSIBLE PARTY_____DATE_____

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Date: _____ Name: _____ DOB: _____

Birth History: _____ BW: _____ HT: _____

Complication:

Past History:

Hospitalization: Medication:

Surgeries: Allergies:

Social History:

Family History:

REVIEW OF SYSTEMS: INFORMANT: _____

✓ YES / ✖ NO: IF YES, PLEASE EXPLAIN:

_____ Head (headache, trauma, abnormal size, etc.) _____

_____ Skin (rashes, lumps, birth marks, jaundice, etc.) _____

_____ Eyes (vision, strabismus, glasses, contacts, infections, etc.) _____

_____ Ears (hearing, tubes, infections, trauma, etc.) _____

_____ Nose (bleeding, obstruction, drainage, snoring, allergies, etc.) _____

_____ Mouth, Throat, Teeth (dental caries, teeth problems, recurrent strep, tonsils, palate, tongue problems) _____

_____ Neck (movement, masses, nodes, thyroid, symmetry, etc.) _____

_____ Chest/Lungs (pneumonia, wheeze, cough, apnea, choking, breathing problems, asthma, pain) _____

_____ Heart (murmurs, high blood pressure, palpitation, exercise intolerance, rheumatic fever, etc.) _____

_____ Gastrointestinal (constipation, diarrhea, abdominal pain, bleeding, ulcers, worms, reflux, etc.) _____

_____ Breast (development, masses, discharge, etc.) _____

_____ Musculoskeletal (deformities, gait, joint swelling, hips, arthritis, knee pain, dislocation, fractures, neck injury, back problems, etc.)

_____

_____ Urinary (enuresis, infection, nocturia, urgency, frequency, blood in urine, urethral reflux, etc.) _____

_____ Endocrine (growth, polyuria, polydipsia, menstrual, palpitation, thyroid problems, etc.) _____

_____ Neurology (seizures, apnea, headaches, gait, speech, concussion, diplopia, education achievement, etc.) _____

_____ Hematology (transfusion, anemia, bleeding, bruises, etc.) _____

_____ Unexplained Fevers, Pica _____

I, _____, authorize payment of medical benefits to the treating physician.

I, _____, authorize medical treatment of myself and/or any minor children by the treating physician of Pediatrics and Endocrinology.

HIPAA Compliance form given to Guardian/Patient. Form and Information about HIPAA also available on clinic web portal at http://www.khateeb-yourmd.com.