PATIENT INFORMATION AND HISTORY

Patient Name_____ DOB_____ Sex **M** **F**
Primary Phone #_____ e-mail Address_____
Patient Address_____
Street City State Zip

Mother's Name_____
Address_____
_____
DOB:_____ Phone #_____
Employer_____
Occupation_____

Father's Name_____
Address_____
_____
DOB:_____ Phone #_____
Employer_____
Occupation_____

Patient Insurance Co. _____ Through: □ Mother □ Father
Pharmacy_____
Child Cell Phone #_____

LIST OF SIBLINGS AND THEIR BIRTHDAYS

_____ _____
_____ _____

FAMILY HISTORY

If a family member has had any of the following problems, check the box and list the appropriate family member.

M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

□_____ Deafness
□_____ Allergies
□_____ Drug Allergies
□_____ Asthma
□_____ Eczema
□_____ High Cholesterol
□_____ High Blood Pressure before age 50
□_____ Heart attack/stroke before age 50
□_____ Anemia/Blood Disorders
□_____ Diabetes
□_____ Learning Disorder
□_____ ADHD
□_____ Anxiety/Depression
□_____ Seizures
□_____ Sudden Death

NEWBORN HISTORY

Term of Pregnancy_____weeks Obstetrician_____ Hospital_____
Birth Weight_____ Birth Length_____ Discharge Weight_____ Apgars_____
Delivery: □ C-Section □ Vaginal Jaundice: □ Yes □ No Phototherapy: □ Yes □ No
Breastfeeding: □ Yes □ No Bottle feeding: □ Yes □ No
Are there any smokers in the home: □ Yes □ No

I hereby consent to medical treatment for this child. I hereby authorize my insurance benefits to be paid to Maumee Pediatric Associates, LLC, realizing I am responsible to pay for non-covered services and any copays at time of service.

Parent/Guardian Signature Date