Patient's Name ____ **Allergies?** ______________________________________

Phone (________**)** ______________________ **Birth Date** ______ / ______ / ______ **Soc Sec #** ________ - ______ - __________

Address _______________________________________ **City** _______________________ **ST** ________ **Zip** ____________

Email Address____

Daycare/School ________________________ **Religion** __________________ **Place of Birth** _________________________

Mother's Name _______________________________ **D.O.B.** _____ / _____ / _____ **Soc Sec #** ______ - ______ - __________

Address ____ **Home Phone (**_______**)** ____________________

Drivers Lic # ____________________________________ **Alternate/Emergency Phone (**_______**)** ____________________

Employer & Job Title ____ **Work Phone (**_______**)** ____________________

Father's Name _______________________________ **D.O.B.** _____ / _____ / ______ **Soc Sec #** _______ - _____ - _________

Address ____ **Home Phone (**_______**)** ___________________

Drivers Lic # ____________________________________ **Alternate/Emergency Phone (**_______**)** ____________________

Employer & Job Title ____ **Work Phone (**_______**)** ____________________

Emergency Name ______________________________ **Relationship** ________________ **Phone (**______**)** _______________

Do You Have Health Insurance? _________ **Name of Company** ____

************ **PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST TO COPY AND VERIFY** **************

Brothers & Sisters	**Birth Dates**	**School/Daycare**	**Health Problems**

Patient's Significant Health Problems and/or Hospitalizations:

Childhood Illnesses in Family (Grandparents, Parents, etc):

Referred By: ____

INSURANCE AUTHORIZATION/GUARANTEE OF PAYMENT:

I authorize Lake Pediatrics to file my insurance. I authorize the release of any medical or other information necessary to process claims. I understand and agree that I am responsible for any deductibles or fees that my insurance company does not pay. If my insurance company pays me directly, I agree to immediately forward the total payment to Lake Pediatrics. I understand that any portion of a claim that my insurance does not pay is my responsibility. In the event that a claim is filed on my behalf and my insurance does not pay it within a reasonable length of time, I understand that payment is my responsibility. I understand that a service charge equal to 1.5% per month (18% annually) or a minimum of $2.00 will be added to my account for balances over 30 days old.

I authorize payment of medical benefits to Lake Pediatrics for services rendered.

Insured's or Authorized Person's Signature ____ **Today's Date** _______________

PLEASE FILL OUT EVEN IF YOU HAVE DONE SO BEFORE. ANYSMALL CHANGE CAN BE IMPORTANT. THANK YOU.

PATIENT QUESTIONNAIRE

We request this questionnaire be complete in order to allow us to provide your child the finest medical care

Patient's Name ___________________________________ **Date of Birth** ___________________________________

Past Medical History

Any allergies to medicine? ☐ Y ☐ N if yes please list ____

Any food/airborne allergies? ☐ Y ☐ N if yes please list ____

Any hospitalizations? ☐ Y ☐ N if yes for what and dates _________________________________

Any serious accidents? ☐ Y ☐ N if yes please list and give dates ___________________________

Any operations? ☐ Y ☐ N if yes please list and dates _______________________________

Any ear infections? ☐ Y ☐ N if yes how often and last date ____________________________

Any pneumonia? ☐ Y ☐ N if yes please give dates __________________________________

Any bronchitis? ☐ Y ☐ N if yes please give dates __________________________________

Any asthma? ☐ Y ☐ N if yes age when first diagnosed __________________________

Any urinary tract infections? ☐ Y ☐ N if yes please give dates __________________________________

Family History **(please check and give relationship to your child)**

Allergies/hay fever __________________________ Thyroid disease __________________________________

Cystic Fibrosis _____________________________ Kidney disease ___________________________________

Tuberculosis TB ____________________________ Bleeding disorder/hemophilia _______________________

Lung disease _______________________________ Sickle cell disease or trait __________________________

Heart disease _______________________________ Cancer ____

Mental retardation ___________________________ Childhood onset diabetes __________________________

Mental illness ______________________________ Adult onset diabetes________________________________

Seizures ___________________________________ Other diseases ____________________________________

Social History **(please check all that apply)**

Are parents ☐ married ☐ divorced /if divorced who has custody _____________________ ☐ separated ☐ single

Where do you live? ☐ apartment ☐ single-family house ☐ with relatives ☐ with friends

Does your home have ☐ window air conditioning ☐ central heat/air ☐ space heaters ☐ wood heating

☐ city water / what city ____________________________ ☐ well water ☐ bottled water ☐ pets in the home/if yes what kind and how many ______________________ ☐ smokers in the home /if yes who _______________________

Birth and Development

Birth weight ___________ ☐ vaginal birth ☐ c-section/for what reason? __________________________________

☐ full term ☐ premature/weeks gestation? _______ ☐ oxygen needed at birth/how long? ___________________

☐ baby jaundiced/yellow ☐ antibiotics given in nursery/for what? __________________________ ☐ IV in nursery

Age when 1st walked _________________ Speaking ability for age: ☐ average ☐ above average ☐ below average

Are there any other problems or concerns we should know about? ____

____