Patient's Name _____ Allergies? _____ Sex? M / F / Other

Phone (_____) _____ Birth Date _____ / _____ / _____ Soc Sec # _____ - _____ - _____

Address _____ City _____ ST _____ Zip _____

Email Address_____

Daycare/School _____ Religion _____ Place of Birth _____

Guardian/Mother's Name _____ D.O.B. ____ / ____ / ____ Soc Sec # _____ - _____ - _____

Address _____ Home Phone (_____) _____

Drivers Lic # _____ Alternate/Emergency Phone (_____) _____

Employer & Job Title _____ Work Phone (_____) _____

Guardian/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 **********

Referred By: _____

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

Patient's Significant Health Problems and/or Hospitalizations:

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

INSURANCE AUTHORIZATION/GUARANTEE OF PAYMENTAND CONSENT TO TREAT:

I give consent for Lake Pediatrics to see my child for medical services

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.

If I do not have insurance at this time. I agree to pay Lake Pediatrics directly for services rendered at time of visit unless otherwise arranged ahead of time.

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. ANY SMALL 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 _____

Intellectual Disability _____ 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? _____

_____