Patient Registration

Please fill out this form COMPLETELY and print LEGIBLY.

Patient/Child

Child's SS# : _____ Address: _____
Last Name: _____ City: _____ State: _____
First Name: _____ Zip: _____ Phone: _____
Nickname: _____ Date of Birth: _____ Sex: _____

Mother's Name: _____ DOB: _____ SS#: _____
Mother's Address: _____
Employer's Name: _____ Occupation: _____
Phone #: Home: _____ Cell: _____ Work: _____

Step Parent? NO YES *(If yes, please provide name and phone number)*
Step Parent Name: _____ Phone #: _____

Father's Name: _____ DOB: _____ SS#: _____
Father's Address: _____
Employer's Name: _____ Occupation: _____
Phone #: Home: _____ Cell: _____ Work: _____

Step Parent? NO YES *(If yes, please provide name and phone number)*
Step Parent Name: _____ Phone #: _____

Patient Lives With:

Name: _____ Phone # : _____
Address: _____
City: _____State: _____ Zip: _____
Relationship to patient: _____

Primary Insurance Information/Responsible Party

Insurance Company: _____ Responsible Party SS#: _____
Last Name: _____ Address: _____
First Name: _____ City: _____ State: _____
Date of Birth: _____ Zip: _____ Phone#: _____
Employer: _____
Employer Address: _____
City: _____ State: _____ Zip: _____ Phone #: _____

Nearest Relative or Friend (NOT living with you)

Name: _____ Phone # : _____
Address: _____
City: _____State: _____ Zip: _____
Relationship to patient: _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT: I authorize my family insurance benefits to be paid directly to Arvada Pediatrics and the release of any pertinent medical information. I understand that I am financially responsible for any services not covered by my insurance, as verified by the information above.

Signature: _____ Date: _____

Arvada Pediatric
ASSOCIATES

New Patient Information

(Information will be strictly confidential)

Child's full legal name: _____ Date of Birth: _____

Child's medical history:

1 Any allergies to medicines? (list) _____

2 Other allergies? (list) _____

3 Hospitalizations? (list reason and age):

_____

_____

4 Surgeries? (list reason and age):

_____

_____

5 Check any of the following that apply:

____ asthma	____ high blood pressure
____behavioral problems	____ kidney disease
____ cancer	____ psychiatric illness
____ convulsions	____ recurrent ear infections
____ diabetes	____ urinary tract infections

Other chronic problems: _____

6 Was the child born on time (within 3 weeks)? ____ yes ____no

If NO, how early? _____

7 Birth weight: _____

8 Problems while in the newborn nursery? ____ yes ____no

If YES, specify: _____

9 Problems as an infant? ____ yes ____no

IF YES, specify: _____

10 Has the child's development seemed normal? ____ yes ____no

If NO, specify: _____

FAMILY AND SOCIAL HISTORY

1. Parents are: ____married ____ single ____separated ____deceased
   ____ divorced and single ____ divorced and remarried
2. List names and dates of birth of other children living at home. (includes last names if different and note if from previous marriage or adopted):
   A. _____ B. _____
   C. _____ D. _____
   E. _____ F. _____
3. List names and date of birth of other children NOT living at home (includes last names if different and note if from previous marriage or adopted):
   A. _____ B. _____
   C. _____ D. _____
   E. _____ F. _____
4. Adults, other than parents, living at home. (Include relationship, if any).
   A. _____ B. _____

FAMILY'S MEDICAL HISTORY:

1. Check any of the following that apply (to the parents):

____anorexia	____ diabetes
____ arthritis	____ drinking/drug problems
____ asthma	____ heart disease
____ bleeding problems	____ high blood pressure
____ blood clots	____ kidney disease
____ cancer	____ psychiatric illness
____ convulsions	____ neurological disease

   Other chronic/debilitating diseases: _____

2. Check any of the following that apply (to other children):

____anorexia	____ diabetes
____ arthritis	____ drinking/drug problems
____ asthma	____ heart disease
____ bleeding problems	____ high blood pressure
____ blood clots	____ kidney disease
____ cancer	____ psychiatric illness
____ convulsions	____ neurological disease

   Other chronic/debilitating diseases: _____

3. Extended family:
   Genetic diseases (diseases which run in the family): _____

4. Check any of the following that apply (in males under 60 or in any female relative):

____heart attack	____ stroke
____ bypass surgery	____ angina

5. Close friends and family members:
   Does anyone currently have a very serious or terminal illness? ____ yes ____ no
   If YES, specify: _____
   Any recent deaths? ____yes ____ no
   If YES, who? _____

PREVENTATIVE HISTORY:

1. Is your child using a car seat, booster seat, seat belt, or none of these? _____
2. Do you have a thermometer at home? ____ yes ____ no
3. Do you know how to take a rectal temperature? ____ yes ____ no
4. Do you have Acetaminophen (Tylenol) or Ibuprofen (Motrin, Advil) at home? ____ yes ____ no
5. Cigarette, cigar or pipe smokers (check all that apply):
   ____ mom ____ dad ____ Other: _____
6. Marijuana use in the home (check all that apply):
   ____ mom ____ dad ____ Other: _____

7. Guns in the home? ____ yes ____ no
   If so, are they locked in a gun safe? ____ yes ____ no