Pediatric Patient Form

Patient's Last Name: ______________________ First Name: ______________________ Middle: __________

Date of Birth: _____/_____/_____ Sex: ____________ SS#: ______________________

Street Address: ____

City: ______________________ State: ________ ZIP: ____________

Home Phone: (____) ____________ Work Phone: (____) ____________ Cell Phone: (____) ____________

E-Mail: ____

Birth History

Premature? ______________________ Birth Weight: ______________________

Any treatment during the first month of life: ______________________

Patient History

Allergies: ______________________

Are immunizations up to date? ______________ Has your child had the chicken pox or the vaccine? ______________

Reactions to immunizations: ______________________

Hospitalization, accidents, or injuries: ______________________

Existing conditions (such as asthma, ADHD): ______________________

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Has your child's growth and development always been normal? ______________________

Is your child taking medications on a regular basis? (e.g., Ritalin) If so, list: ______________________

Family History

Fathers's Full Name: ______________________ DOB: ____________ Occupation: ____________

Employer: ______________________ Work Phone: (____) ____________

Mother's Full Name: ______________________ DOB: ____________ Occupation: ____________

Employer: ______________________ Work Phone: (____) ____________

Please circle if anyone in the family has had these conditions

Asthma Cancer Cystic Fibrosis Diabetes Heart Disease High Blood Pressure High Cholesterol Sickle Cell Disease

Other ____

Please list patient's siblings and their birth dates ______________________

Insurance Information

(Circle One) Private Medicaid / Carolina Access None

Please bring a copy of the patient's insurance card so we may file the insurance.

I authorize the release of any information necessary to process my child's claim.

Signature: ______________________

Relationship: ______________________

DukeHealth

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