Duke Primary Care

Pediatric Patient Form

Patient's Last Name _____ First _____ Middle _____

Date of Birth _____ Sex _____ SS# _____

Street Address _____

City _____ State _____ ZIP _____

Home 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) _____

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

Father's Full Name _____ DOB _____ Occupation _____

Employer _____ Work Number ( ) _____

Mother's Full Name _____ DOB _____ Occupation _____

Employer _____ Work Number ( ) _____

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 _____

DukeMedicine