Dignity Health Medical Group
Nevada

Please complete the form below. Your Pediatrician will review it with you at the time of your appointment.

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth: _____/_____/_____ Age:_____ SSN:_____-_____-_____

Gender: Male / Female Marital Status: M S D W

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____

Cell Number: ( ) _____ - _____

Work Number: ( ) _____ - _____

Race:

□ Caucasian □ Asian

□ African American □ Pacific Islander

□ Hispanic/Latino □ Native American

□ Do not wish to answer

□ Other: _____

Guarantor/Guardian Information (person responsible for payment)

Responsible Party:

Name: _____ Relationship: _____ Male / Female

Date of Birth: _____/_____/_____ SSN:_____-_____-_____

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____ Cell Number: ( ) _____ - _____

Employer: _____ Work Number: ( ) _____ - _____

Email Address: _____

Additional Responsible Party:

Name: _____ Relationship: _____ Male / Female

Date of Birth: _____/_____/_____ SSN:_____-_____-_____

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____ Cell Number: ( ) _____ - _____

Employer: _____ Work Number: ( ) _____ - _____

Email Address: _____

Emergency Contact

Primary:

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Secondary:

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Primary Care / Referring Physicians

Primary Care Physician: _____ Phone Number: ( ) _____ - _____

Referring Physician: _____ Phone Number: ( ) _____ - _____

Insurance Information

Primary Insurance:

Insurance Name: _____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Employer: _____ Work Phone: ( ) _____ - _____

Secondary Insurance:

Insurance Name: _____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Employer: _____ Work Phone: ( ) _____ - _____

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Medical History

Review of Symptoms

Within the last week has your child had any of the following symptoms

	Yes	No		Yes	No		Yes	No
General			**Respiratory**			**Neurologic**		
Fever			Cough			Headaches		
Night sweats/chills			Wheezing			Seizures		
Decreased appetite			Difficulty breathing			Weakness		
Increased crying			**Cardiovascular**			**Psychiatric**		
Skin			Shortness of breath			Change in sleep pattern		
Itching			Chest pain			Fussiness		
Rash			Difficulty breathing on exertion			**Endocrine**		
New lesion			Sweating while feeding (infants)			Changes in hair		
Excessive sweating			**Gastrointestinal**			**Hematology**		
Eyes/Ears/Nose/Throat			Abdominal pain			Easy Bruising		
Red eye(s)			Vomiting			Enlarged lymph nodes		
Excessive tearing			Diarrhea			**Urologic**		
Eye discharge			Constipation			Pain with urination		
Earache			Difficulty swallowing			Blood in urine		
Ear discharge			**Musculoskeletal**					
Runny nose			Decreased range of motion					
Nasal congestion			Muscle weakness					
Sore throat			Join pain/swelling					

Neck			**Immunizations**		
Neck stiffness			Are your child's immunizations up to date?		
Swollen glands			If possible, please show us your child's vaccine record		
Has your child had:	☐ Chicken Pox ☐ Measles ☐ Scarlet Fever ☐ Mumps ☐ Other:				

Family History

Is there a family history of the following:

	Yes	No	Relationship to Child		Yes	No	Relationship to Child
Diabetes				Cancer			
Allergies				Heart Disease			
Convulsions				Tuberculosis			
Asthma				Other_____			

Family Profile

	Name	Age	Health	Child's Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Other	
Parent				Highest level of Education?	Occupation
Parent				Highest level of Education?	Occupation
Sibling				Number of people living in your house? _____	
Sibling				Any smokers in your house? ☐ Yes ☐No Outside? ☐ Yes ☐ No	
Sibling				Pets? ☐ Yes ☐ No What kind? _____	
Sibling				Number of people living with your child: _____	

Does your child have frequent contact with anyone who is receiving chemotherapy, on medications regularly such as steroids or has had an organ transplant? ☐ Yes ☐ No

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Medications					
Name	dose (mg)	times/day	Name	dose (mg)	times/day

Pharmacy information	
Name:	Phone:
	Fax:
Address:	

Past Medical History			
Serious Injuries or Illness:	**Allergies:**		
	Drugs: ☐ Yes ☐ No	Food: ☐ Yes ☐ No	Latex: ☐ Yes ☐ No
	Environmental: ☐ Yes ☐ No		
	Allergy Testing: ☐ Yes ☐ No		
Hospitalizations (including NICU at birth):	Please explain all Yes answers:		
Surgeries:			

Development	
School History:	
My child is in: ☐ Daycare ☐ Preschool ☐ Public School ☐ Private School ☐ Home School	
School Name:	Year in School:
School Problems: ☐ Yes ☐ No	Discipline or Behavior Problems ☐ Yes ☐ No
Has your child been seen by a Psychologist, Speech Therapist or Special Teachers? ☐ Yes ☐ No	
Is your child in any special classes? ☐ Yes ☐ No	
Please explain any yes answers:	

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Development (continued)				
*** Children Under Five Only**				
Age when your child first:				Any known development delays? ☐ Yes ☐ No
Rolled		Walked		If yes, please explain:
Sat		First Teeth		
Crawled		Toilet trained		
First Word		Talked		

*** Children Under Two Only**			
Birth History:			
Mother's 1st, 2nd, 3rd pregnancy:		Method of Delivery: ☐ Vaginal ☐ Caesarian section	
Weeks pregnant at delivery:		Birth Weight:	
Mothers age at patient's birth:		Birth Hospital:	
Fathers age at patient's birth:		Days in Hospital	
Problems with: ☐ Sleep ☐ Urination ☐ Stooling ☐ Weight ☐ Height ☐ Behavior			
Problems during delivery?			
Passed newborn hearing screen? ☐ Yes ☐ No		Problems in the first month?	
Feeding history:	☐ Breastmilk ☐ Formula ☐ Both		
Age started solid food:	Feeding issues or intolerance:		
Special Diet?			

Please Explain any yes answers:

Comments/ Concerns/ Extra Space