BERGEN PEDIATRIC SPECIALISTS, P.A.
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Pediatric & Adolescent Medicine

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Patient Registration

Date: _____

Last First Middle

Patient Name: _____

Birth Date: _____ Sex: M ____ F ____

Home Address: _____

_____ Zip Code _____

Home Phone: _____

Billing Address if Different: _____

_____

Emergency Phone: _____

Relation Ship: _____

Previous Doctor: _____

Address: _____

_____

Phone #: _____

Referred By: _____

Mothers Name: _____

Profession: _____

Employer: _____

Job Address: _____

_____

Father Name: _____

Profession: _____

Employer: _____

Job Address: _____

_____

Do You Have Medical Insurance? Yes _____ No _____

If Yes Policy Holders Name and SS#: _____

_____

If No Who is Responsible for account?: _____

Prenatal History

Pregnancy Complications: _____
Illnesses: _____
Trauma: _____

Medications: _____
X-Rays: _____

Was there any staining or bleeding during the pregnancy? _____
Did you have any diseases during pregnancy? _____
Any other difficult(ies) during pregnancy? _____

Birth and Neonatal Period

Hospital of Birth: _____
Address: _____
Phone #: _____
Labor: Duration _____
Delivery: Normal _____ C-Section _____ Breech _____
Forced _____ Other: _____
Condition at Birth: _____
Condition First Month: _____
Birth Weight: _____ lb _____
Apgar: (1 Minute) _____ Apgar: (5 Minute) _____

Circumcision? _____
Birth Heigh: _____ Circ: _____
Cyanosis: _____ Head Cir: _____
Jaundice: _____
Blood Group: _____ RH _____ Coombs _____
Hepatitis B (Date) _____ PKU (Date) _____
Obstetrician Name: _____
Obstetrician Phone #: _____
Complications: _____
Prematurity: _____

Feeding History

Breast: _____ Formula: _____ Vitamins: _____ Fluoride: _____
Present Diet: _____ Feeding Habits: _____ Appetite: _____
Likes: _____
Dislikes: _____

Vomiting: _____
Sensitivity: _____
Stools: _____
Hives: _____

Growth and Development

Smiled: _____ Sat Up: _____
Walked: _____ First Teeth: _____
Words: _____

Bladder Control: Day _____ Night: _____
Head Held: _____ Stood: _____
Short Sentences: _____ Bowel Control; _____

Accident Prevention

Do you keep your medicine cabinet out of child's reach? Yes ____ No ____
Do you regard your child(ren) as clumsy? Yes ____ No ____
Do you regard your child(ren) as accident prone? Yes ____ No ____

School Performance

Present Grades in School: Good ____ Average ____ Poor ____
Grades Repeated: _____
Grades Skipped: _____
School Behavior Problems: _____ Describe: _____

_____
_____
Relationships With Friends and Peers: ____ Describe: _____
_____

Adolescence

Is there a history of drug intake? Past _____ Present _____
Is there a history of alcohol intake? Past _____ Present _____
Is there a history of smoking? Past _____ Present _____

High School Grades: _____
Performance: _____

Young Adult

Are you sexually active? Yes _____ No _____
Method of contraception: _____

College Education: _____
Employment: _____

Job Performance

Employed? _____
Where? _____

Type of occupation: _____
Are you satisfied with your job? _____

Family Social History

Fathers Age: _____
Past Health: _____
Present Health: _____
Occupation: _____
Sibling # 1 age: ____ Sex ____ Health Status: _____
Sibling # 2 age: ____ Sex ____ Health Status: _____

Mothers Age: _____
Past Health: _____
Present Health: _____
Occupation: _____
Sibling # 3 age: ____ Sex ____ Health Status: _____
Sibling # 4 age: ____ Sex ____ Health Status: _____

Family Medical History

In your family, is there a history of:

	Name of Person	
____ Heart attack under age 50		
____ Hearing loss		
____ Bleeding disorder		
____ Rheumatic fever		
____ Hereditary disease		
____ Renal disease		
____ Allergies		
____ Emotional Disturbance		
____ Cancer		
____ Thyroid disease		
____ Epilepsy		
____ Blood dyscrasia		
____ Mental illness		
____ Tuberculosis		
____ Gastro intestinal disease		
____ Arthritis		
____ Migraines		
____ Miscarriage		
____ Substance abuse		
____ Alcohol abuse		
____ Use of tobacco		
____ AIDS		
____ HIV Positive (asymptomatic)		

Fathers blood type: _____ RH _____
Mothers blood type: _____ RH _____
Psychosocial history: _____
Education, behavioral or family problems: _____

PsychoSocial Development

Sleeping problems: (Type) _____
Pica: _____
Rocking: _____
Nailbiting: _____
Headbanging: _____
Encopresis: _____
Thumbsuking: _____
Bedwetting: _____

Breath holding spells: _____
Kicking: _____
screaming at night: _____
Temper tantrums: _____
Biting:_____
Nose Piking: _____
Toe walking: _____

Social and Environmental

Family Structure and Marital Status: _____
Ethnic and Linguistic Status: _____
Child cared and food prepared by:
_____

Nutrition: _____

Neighborhood and Housing status: _____
Toxic and infections exposure: _____
Others: _____

Child Medical History

Check all that apply:

Age
——— Chicken pox
——— German measles
——— Anemia
——— Diabetes
——— Palpitations
——— Delayed blood clotting
——— Chemical dependency
——— Recovering Chem, depend
——— Mitral valve proplase
——— Shortness of breath
——— Convulsion
——— Severe/frequent cold
——— Speech problems
——— Swelling of hands and feet
——— Frequent ear infections
——— Cancer
——— AIDS

Age
——— Measles
——— Mumps
——— Arthritis
——— Heart murmur
——— Asthma
——— Epilepsy
——— Whooping cough
——— Scarlet fever
——— Chest pain
——— Joint pain
——— Rheumatic heart
——— High blood pressure
——— Fainting spells
——— Low blood pressure
——— Smoking problems
——— Dizzy spells
——— HIV Pos.
——— Severe/freq. headaches

Age
——— Skin Problems
——— Hearing Problems
——— Teeth/gum Problems
——— Exposure to TB
——— Kidney Problems
——— Eye Problems
——— Constipation
——— Foot Problems
——— Appetite Problems
——— Bed wetting
——— Subacute bacterial endo.
——— Weight Problems
——— Allergies
——— Hyperactivity
——— Hemophilia
——— Menstrual Problems
——— Rheumatic fever

Does your child tale any forms of medication regularly? Yes _____ No _____
If the answer is yes please describe: _____

How does your child perform in school? _____

Does your daughter use tampons? _____

Is your child allergic to any of the following:
——— Penicillin
——— Codeine
——— Aspirin
——— Adhesive tape
——— Foods (Describe): _____
——— Other (Describe): _____

Questions: We appreciate your answers and comments

1. What do you like/dislike to see in a pediatric office:

	Like	Dislike
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____

2. As a parent:

	Yes	No
A. Do you exercise regularly?	_____	_____
B. Do you smoke?	_____	_____
C. Do you take vitamins?	_____	_____
D. Do you drink water?	_____	_____
E. Do you keep your appointment for annual checkup?	_____	_____
F. Do you believe in prayer and/or meditation?	_____	_____

3. Do you care to bring to your children's pediatrician your concern about his office staff or himself? Yes _____ No _____

   Comments: _____

   _____

4. Do you care to give your child pediatrician an opportunity to satisfy you concerns before leaving him? Yes _____ No _____

   Comments: _____

   _____

5. Do you care to refer patients to him? Yes _____ No _____

   Comments: _____

   _____

Please:

1. Be on time.
2. Have your insurance ID card on all visits.
3. Pay your COPAY at time of visit.

4. If you are a new patient:
   a. Request your children's records to be transferred ASAP.
   b. Change your PCP before next visit.

5. Share your concerns with doctor at each and every visit.
6. Make appointment at all times, except new emergency.
7. Introduce us to your church, school, etc.
8. Pray for health.
9. Believe in love, peace, humanitarianism and justice.
10. recommend us to others.

QUESTIONS/COMMENTS:

_____

_____

_____

_____

_____

Legal Guardian Signature