New Patient Registration

Patient name: ______________________________ DOB: ______________

Address: ____

Phone: ___________________________ SSN: ____________________

Previous pediatrician: ____

Preferred pharmacy: ____

Current medications: ____

Allergies: ____

INSURANCE INFORMATION

Insurance: ________________________ Member ID: __________________

Subscriber: ____

DOB of subscriber: _____________________ SSN: ___________________

DEVELOPMENTAL HISTORY (FOR PATIENTS UNDER 3 YEARS)

Place of birth: ______________________ Hospital: __________________

Birthweight: ___________________ Delivery: ◯ vaginal ◯ C-section

Was mother ill during birth? ◯ Yes ◯ No

Was baby born on expected date? ◯ Yes ◯ No

Did your baby have any medical problems after being born? ◯ Yes ◯ No

Did your baby have to stay in the hospital longer than expected? ◯ Yes ◯ No

When did your child: sit ___________ walk ___________ start talking ___________

SOCIAL HISTORY

Mother's name and occupation: _____________________________________

Father's name and occupation: ______________________________________

Who all lives at home: ____

Does your child attend daycare? ◯ Yes ◯ No

Any family/social issues we should be aware of (ex: DHS involvement, family separation)?

MEDICAL HISTORY

Does your child have any underlying medical conditions?
(Example: eczema, asthma, heart problems, seizures, ear infections, UTIs)

Does your child have any underlying psychological conditions?
(Example: anxiety, depression, ADHD, learning disorder)

Any medical problems that run in the family?
(Example: cancer, thyroid disease, diabetes, heart disease, high blood pressure, kidney disease)

IMMUNIZATION HISTORY

Is your child up to date on immunizations? ◯ Yes ◯ No

Any allergic or bad reactions to previous immunizations? ◯ Yes ◯ No

Has your child ever received the BCG vaccine for tuberculosis? ◯ Yes ◯ No

Has your child ever tested positive for tuberculosis? ◯ Yes ◯ No

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid to Northern Pediatrics. I authorize Northern Pediatrics or my insurance company to release any information necessary for continuation of care or processing claims for myself or my dependent.

I acknowledge that I have received and read a copy of Northern Pediatrics privacy policy.

Patient/guardian signature Date