PEDIATRIC INTAKE FORM

Print, Fill And Bring To Your First Visit

Patient Name: _____ Date of Birth: _____ Sex:_____

Address: _____ City: _____State:_____Zip Code: _____

Ethnic Group: _____( )Hispanic: ( )Non-Hispanic Other:_____

Patient Race: _____ Patient SS#: _____

Patient contact information (PLEASE PROVIDE AT LEAST TWO PHONE NUMBERS)	
Name:	Name:
Relationship to patient:	Relationship to patient:
Legal Guardian: ❒YES ❒NO	Legal Guardian: ❒YES ❒NO
Address (if different from Child):	Address (if different from Child):
SSN#:	SSN#:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Date of Birth:	Date of Birth:
Employment (circle): unemployed, part-time, full time	Employment (circle): unemployed, part-time, full time
Who do you give Permission to bring your Child to Dr. Mawri's office for treatment? (Fill in below) **Emergency Contact (other than Parent):**	
Name:	Name:
Relationship to patient	Relationship to patient
Phone #:	Phone #:
Name:	Name:
Relationship to patient	Relationship to patient
Phone #:	Phone #:

Primary Health Insurance Information		
Primary Insurance:	Policy Number:	Group Number:
Policy Holder's Name:	Policy Holder's Date of Birth:	
Policy Holder's Name of Employer:		

Secondary Health Insurance Information		
Secondary Insurance:	Policy Number:	Group Number:
Policy Holder's Name:	Policy Holder's Date of Birth:	
Policy Holder's Name of Employer:		

Policy Holder's Name of Employer: _____

E-Mail address:

_____

Preferred ***Pharmacy*** Name and address:_____

How Did you hear About us?_____

My Chart Access: My chart is a patient portal allows patients to obtain access to their medical history and patient chart from home. It is utilized with our office as well as a multitude of hospitals we now provide this service to our patients. More information is available upon request
Would you like to register for My chart? ❒ YES ❒ NO

What are your Top Three Health Concerns for your child?

1) _____

2) _____

3) _____

Current Medications:

1.
2.
3.
4.

Current Supplements:

1.
2.
3.
4.

Allergies to Medications:

1.
2.
3.

Known Allergies

1.
2.
3.

Reaction:_____

Reaction: _____

Patient Health History:

Has your child had any of the following conditions in the past or currently?

❒ Asthma
❒ Ear Infection
❒ Eczema
❒ Rashes
❒ Allergies
❒ Chicken Pox
❒ Bladder/Urinary Infection
❒ Colic
❒ Bronchitis
❒ Strep Throat
❒ Constipation
❒ Heart Problem
❒ Other

PRENATAL HISTORY:

While pregnant, did mother have:

1.	Bleeding or spotting	No ❒	YES ❒
2.	German Measles (Rubella)	No ❒	YES ❒
3.	Gestational Diabetes	No ❒	YES ❒
4.	High Blood Pressure	No ❒	YES ❒
5.	Premature Labor	No ❒	YES ❒
6.	Threatened miscarriage	No ❒	YES ❒
7.	Toxemia	No ❒	YES ❒

Birth History:

1. Where was the Child born? _____

2. Duration of Labor? _____

3. Gestational Age? _____

5. What was the method of delivery?

- ❒Breech
- ❒Caesarean (Please state reason):_____
- ❒Forceps
- ❒ Vaginal

6. Child's birth weight: _____

7. During the hospital stay, did child have any of the following?

A. Antibiotic treatment	YES ❒	NO❒
B. Blue spells	YES ❒	NO❒
C. Convulsions	YES ❒	NO❒
D. Jaundice	YES ❒	NO❒
E. Skin rash	YES ❒	NO❒

11. How was/is baby fed?

- ❒Breast fed
- ❒Bottle fed - breast milk
- ❒Bottle fed - formula
- ❒Both

	YES	NO	Date		YES	NO	Date		YES	NO	Date
Adenoidectomy				Fracture Surgery				ROP Surgery			
Appendectomy				Fundoplication				Gallbladder			
Gastrostomy				Tonsillectomy				Circumcision			
Heart Surgery				Tracheostomy				Cleft Lip			
Hip Surgery				Ear Tubes				Cleft Palate			
Inguinal Hernia				Umbilical Hernia				Cosmetic			
Lymph node				Dental/Restoration				PDA Repair			

Surgical History

1.
2.
3.

Family History:

1. Is there tobacco use in/around your household? No ❒ YES ❒

Is there a history in the **family/a blood relative of**: (if yes **state relationship**)

Number	History of	yes	no	Patient and/or sibling?	Paternal (fathers side) Please **write** who has these problems: aunt, uncle, grandma, grandpa, etc.	Maternal (mothers side) Please **write** who has these problems: Aunt, uncle, grandma, grandpa, etc.
	Allergies					
	Anxiety					
	Depression					
	Asthma					
	Birth Defects/Genetic Problems					
	Cancer:					
	a. Brain					
	b. Breast					
	C. Colon					
	D. Ovarian					
	E. Skin					
	F. Other					
	Diabetes					
	Hearing loss					
	Heart attack					
	High Blood Pressure					
	High Cholesterol					
	Learning Disability					
	Mental illness					
	Seizures					
	Thyroid problems					
	Tuberculosis					
	Other					

Office Policies

Payment Policy: 100% of all doctor visits, other treatments, and supplements fees are due at the time of services. We accept card, cash and/or checks as payment. All sales are final. We cannot provide refunds or exchanges.

Cancellation Policy/ No show: Last minute cancellations of scheduled appointments or no shows are challenging to fill, wasteful of an opportunity for another patient, and costly for the clinic. We therefore require changes or cancellations to be made at **least 24 hours prior** to your scheduled appointment. Otherwise, you will be charged **$35.00**

I understand that I am financially responsible for all charges regardless of insurance coverage and or treatment outcome. I further understand that 100% of fees are due at the time service is rendered, and that all sales are final. I understand that I will be charged for any appointment missed or cancellation less than 24 hours in advance as explained above. I hereby agree to pay any and all charges.

The information I have provided is accurate and true to the best of my knowledge.

Parent/guardian signature: _____ Date: _____