REGISTRATION FORM

(Please Print)

Today's date:			PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Home phone no.:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City:	State:	ZIP Code:

Chose clinic because/Referred to clinic by (please check one box):		❑ Dr. ______	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Other	
Other family members seen here:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No				
Please indicate primary insurance	❑ Aetna	❑ BCBS PPO	❑ BCBS Blue Choice	❑ Cigna	❑ Humana ❑ UHC	❑ Medicare
❑ Medicaid	❑ BlueCross Community	❑ IlliniCare Health	❑ Meridian Health	❑ Molina Healthcare	❑ YouthCare	❑ Other______

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Child	❑ Other		

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Thrive Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian signature __________________________ _Date_ __________

History Form

Dear Parent:

This is a health questionnaire on your child. **Please complete this form, and bring it with you at the time of an appointment.**

Date Completed: ____________

Child's Name: ____________ Date of Birth: ____________

Contact Information for Parent 1

Name: ____________ Email: ____________

Home Address: ____________

Home Phone: ____________ Cell/Other: ____________

Contact Information for Parent 2

Name: ____________ Email: ____________

Home Address: ____________

Home Phone: ____________ Cell/Other: ____________

This child lives with:

☐ Mother ☐ Father ☐ Mother/Father ☐ Mother/Partner ☐ Father/Partner ☐ Grandparent/Other

FAMILY HISTORY

1. Parent 1 Name: ____________
   Age: ______ Current Health: ____________
   Past Health Problems: ____________
   Ethnicity: ____________
2. Parent 2 Name: ____________
   Age: ______ Current Health: ____________
   Past Health Problems: ____________
   Ethnicity: ____________
3. Marital Status of Parents: ____________
4. Other Children in Family:

Date of Birth	Gender	Name	Healthy or Medical Issues?

5. Are there cultural or religious practices that might affect your child's medical care? ☐ Yes ☐ No
   If yes, please explain (e.g., blood transfusion, dietary rules, etc.): ____________
6. Is there tobacco use in/around your household? ☐ Yes ☐ No
7. Is there a history in the **family/a blood relative** of:

			If yes, state relationship to child
a.	Allergies	☐ Yes ☐ No	
b.	Anxiety	☐ Yes ☐ No	
c.	Asthma	☐ Yes ☐ No	
d.	Birth Defects/Genetic Problems	☐ Yes ☐ No	

e. Cancer
   i. Brain ☐ Yes ☐ No ______
   ii. Breast ☐ Yes ☐ No ______
   iii. Colon ☐ Yes ☐ No ______
   iv. Ovarian ☐ Yes ☐ No ______
   v. Skin ☐ Yes ☐ No ______
   vi. Thyroid ☐ Yes ☐ No ______
   vii. Other (describe and state relationship to child): ______

f. Depression ☐ Yes ☐ No ______

g. Diabetes ☐ Yes ☐ No ______

h. Hearing Loss ☐ Yes ☐ No ______

i. Heart Attack ☐ Yes ☐ No ______

j. Heart Disease ☐ Yes ☐ No ______

k. Hepatitis ☐ Yes ☐ No ______

l. High Blood Pressure ☐ Yes ☐ No ______

m. High Cholesterol ☐ Yes ☐ No ______

n. Learning Disability ☐ Yes ☐ No ______

o. Mental Illness ☐ Yes ☐ No ______

p. Seizures ☐ Yes ☐ No ______

q. Thyroid Problems ☐ Yes ☐ No ______

r. Tuberculosis ☐ Yes ☐ No ______

PRENATAL & BIRTH HISTORY

1. Any prenatal complications? ☐ Yes ☐ No
2. Was the child full term? ☐ Yes ☐ No
3. Where was the child born? ______
4. What was the method of delivery?
   Breech ☐
   Caesarean (please state reason): ☐
   Forceps ☐
   Spontaneous vaginal ☐
5. Child's birth weight: ______
6. During the hospital stay, did the child have any of the following:
   Antibiotic treatment ☐ Yes ☐ No
   Blue spells ☐ Yes ☐ No
   Convulsions ☐ Yes ☐ No
   Jaundice ☐ Yes ☐ No
   Skin rash ☐ Yes ☐ No
   Did child remain in hospital longer than mother? ☐ Yes ☐ No

7. How was/is baby fed?
   - Bottle ☐
   - Breast ☐

DEVELOPMENTAL HISTORY

1. Has your child had any developmental delays? ☐ Yes ☐ No
2. Does your child receive any developmental services? ☐ Yes ☐ No
   If yes, name of location: ______________________

IMMUNIZATIONS

PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES
And TB (Tuberculosis) Testing or BCG Vaccination

PAST MEDICAL HISTORY

1. Has the child had:
   a. Blood: anemia (iron deficiency, Sickle cell, Thalassemia) ☐ Yes ☐ No
   b. Blood transfusions ☐ Yes ☐ No
   c. Chicken pox (Varicella) ☐ Yes ☐ No
   d. Contusions ☐ Yes ☐ No
   e. Convulsions ☐ Yes ☐ No
   f. Fractures ☐ Yes ☐ No
   g. German Measles (Rubella) ☐ Yes ☐ No
   h. Hospitalizations ☐ Yes ☐ No
   i. Measles (Rubeola) ☐ Yes ☐ No
   j. Meningitis ☐ Yes ☐ No
   k. Mumps ☐ Yes ☐ No
   l. Operations ☐ Yes ☐ No
   If yes, what illness? ______________________
   m. Poison ingestion ☐ Yes ☐ No
   n. Other serious medical illnesses ☐ Yes ☐ No
   If yes, what kind? ______________________
   o. Is your child currently taking any medications, vitamins or herbs? ☐ Yes ☐ No

Medication	**Strength/Dose**	**How Often?**

   p. Reaction to medication or food (allergy) ☐ Yes ☐ No
   If yes, please explain: ______________________

q. Any chronic or recurring pain? ☐ Yes ☐ No
If yes, please explain: ____________________

____

2. Eyes:
   a. Any visual problems? ☐ Yes ☐ No
   b. Do eyes look crossed? ☐ Yes ☐ No
   c. Does the child wear eyeglasses? ☐ Yes ☐ No
3. Ears:
   a. Any hearing problems? ☐ Yes ☐ No
   b. Three or more ear infections? ☐ Yes ☐ No
4. Nose:
   a. Frequent sneezing attacks or rubbing his/her nose? ☐ Yes ☐ No
   b. Frequent nose bleeds? ☐ Yes ☐ No
5. Throat:
   a. Three or more strep throat infections per year? ☐ Yes ☐ No
6. Heart:
   Have you ever been told your child has:
   a. A heart murmur? ☐ Yes ☐ No
   b. A heart defect? ☐ Yes ☐ No
   c. High blood pressure? ☐ Yes ☐ No
7. Lungs:
   Has your child ever had:
   a. Asthma/wheezing? ☐ Yes ☐ No
   b. Bronchitis or pneumonia? ☐ Yes ☐ No
   c. Chronic cough? ☐ Yes ☐ No
8. Does your child tire easily? ☐ Yes ☐ No
9. Abdomen:
   Has your child ever had:
   a. Blood in bowel movement? ☐ Yes ☐ No
   b. Difficulty with appetite or eating? ☐ Yes ☐ No
   c. Frequent abdominal pain? ☐ Yes ☐ No
   d. Frequent vomiting or diarrhea? ☐ Yes ☐ No
   e. Jaundice? ☐ Yes ☐ No
   f. Marked weight loss? ☐ Yes ☐ No
   If yes, please explain: ____________________

   ____
10. Kidney:
   a. Does your child ever complain of burning or frequency of urination? ☐ Yes ☐ No
   b. Does your child wet the bed? ☐ Yes ☐ No
   c. Has there ever been blood in the urine? ☐ Yes ☐ No
   d. Has your child ever had a urinary tract infection? ☐ Yes ☐ No

11. Skin:
    a. Acne? ☐ Yes ☐ No
    b. Any sensitivity or allergy? ☐ Yes ☐ No
    c. Eczema or atopic dermatitis? ☐ Yes ☐ No
12. Extremities:
    Has your child ever had:
    a. Weakness or paralysis of arms or legs? ☐ Yes ☐ No
    b. A persistent limp? ☐ Yes ☐ No
    c. Ever worn corrective shoes or braces? ☐ Yes ☐ No
13. Neurological:
    Has your child ever had:
    a. Breath holding? ☐ Yes ☐ No
    b. Convulsions or seizures? ☐ Yes ☐ No
    c. Dizziness? ☐ Yes ☐ No
    d. Fainting? ☐ Yes ☐ No
    e. Frequent headaches? ☐ Yes ☐ No
    f. Temper tantrums? ☐ Yes ☐ No
14. Is your child:
    a. Impulsive? ☐ Yes ☐ No
    b. Lacking in self-control? ☐ Yes ☐ No
    c. Overactive? ☐ Yes ☐ No
    d. Does your child have problems with:
        i. Attending school? ☐ Yes ☐ No
        ii. Attention span? ☐ Yes ☐ No
        iii. Learning? ☐ Yes ☐ No
        iv. Mood? ☐ Yes ☐ No
        v. Parents? ☐ Yes ☐ No
        vi. Peers? ☐ Yes ☐ No
        vii. Siblings? ☐ Yes ☐ No
        viii. Sleep? ☐ Yes ☐ No
    e. Are there concerns about physical, sexual or emotional abuse? ☐ Yes ☐ No
15. Has your child begun puberty? ☐ Yes ☐ No
16. Any other concerns you would like to discuss? ____________________

____

____

Parent Signature ______ Date ______ Provider Name ______ Date Reviewed ______