PALM BEACH PEDIATRICS, PA

Patient's Last Name: ______________________ Patient's First Name: ______________________

Address: ______________________ City: ______________ State: ______ Zip: __________

Sex: ☐MALE ☐FEMALE Date of Birth ______________ Parent/Guarantor Social Security # ______________

Race (check one) ☐1-American Indian/Alaska Native ☐2-Asian ☐3-Black/African American ☐4-White ☐5-Pacific Islander ☐6-Refuse

Ethnicity (check one) ☐1-Hispanic or Latino or Spanish origin ☐2-Non Hispanic or Latino or Spanish origin ☐3-Refuse

Preferred Language: ______________________ Parents Marital Status: ☐Married ☐Divorced ☐Separated ☐Single

Home Phone: ______________ Cell Phone (Mom) ______________ Cell Phone (Dad) ______________

Email Address: ______________________ Sibling (first, last name, DOB) ______________________

Pharmacy Name: ______________________ Sibling (first, last name, DOB) ______________________

Pharmacy Phone Number: ______________________ Sibling (first, last name, DOB) ______________________

Who referred you to Palm Beach Pediatrics? ______________________

Primary office you will attend: ☐ROYAL PALM BEACH ☐WEST PALM BEACH ☐BOYNTON BEACH

Which Provider do you consider your PRIMARY CARE PROVIDER? ______________________

PRIMARY CONTACT PERSON FOR FAMILY (this primary contact will be the preferred contact person for Reminder calls)

Circle one: Mother / Father

Check one: ☐Biological ☐Step ☐Adoptive ☐Foster ☐Legal Guardian ☐Other: __________

Name: ______________ Home Phone: ______________ Cell Phone: ______________

Address: ______________ Work Phone: ______________ Email: ______________

City: ______________ State: ________ Zip: ________ Date of Birth: ______________

Do you live with patient? ☐Yes ☐No Name of Employer: ______________________

Check preferred means of contact for messages: ☐Home ☐Cell ☐Work ☐Email

Check preferred means of contact for Appointment Reminders: ☐Home ☐Cell ☐Work ☐Email

SECONDARY CONTACT PERSON FOR FAMILY

Circle one: Mother / Father

Check one: ☐Biological ☐Step ☐Adoptive ☐Foster ☐Legal Guardian ☐Other: __________

Name: ______________ Home Phone: ______________ Cell Phone: ______________

Address: ______________ Work Phone: ______________ Email: ______________

City: ______________ State: ________ Zip: ________ Date of Birth: ______________

Do you live with patient? ☐Yes ☐No Name of Employer: ______________________

WHO HAS PRIMARY PHYSICAL CUSTODY? (if applicable) ______________________

(If either biological parent has NO parental rights per a SIGNED COURT ORDER, a copy of that Court Order is required to be on file.)

EMERGENCY CONTACT PERSON (other than either the parent(s) or contact(s) listed above)

Name: ______________ Relationship to Patient: ______________ Phone: ______________

FINANCIAL GUARANTOR: ______________ Relationship to Patient: ______________

Insurance Company name: ______________ Primary Insured name: ______________

ID # or Member # ______________ Group # ______________

PERSONS AUTHORIZED TO BRING CHILD IN FOR APPOINTMENTS - OTHER THAN PARENTS - (must be 18 years or older)

Name: ______________ Relationship to Patient: __________ DOB: ________ Phone: __________

Name: ______________ Relationship to Patient: __________ DOB: ________ Phone: __________

Name: ______________ Relationship to Patient: __________ DOB: ________ Phone: __________

Name: ______________ Relationship to Patient: __________ DOB: ________ Phone: __________

PALM BEACH PEDIATRICS, PA

Patient's Name: ______________________ Patient's DOB: ______________________

PAST MEDICAL HISTORY (Please check YES or NO. Write an explanation of YES answers on the line)

☐Yes ☐No Serious illness or medical condition (ex. asthma, allergies, diabetes, ADHD)______________________

☐Yes ☐No Serious injury or accident ______________________

☐Yes ☐No Surgery ______________________

☐Yes ☐No Hospitalization ______________________

☐Yes ☐No Serious Behavior/Mental Problems/Developmental Delay ______________________

☐Yes ☐No Receiving medical care from a specialist - who?______________________

☐Yes ☐No Taking medication ______________________

☐Yes ☐No Delayed or missing immunizations ______________________

☐Yes ☐No Recurrent medical problem (ex. ear infection, UTI, strep throat) ______________________

☐Yes ☐No Medication Allergies ______________________

Other ______________________

Biological Mother: ______________________ Date of Birth: ______________________

Biological Father: ______________________ Date of Birth: ______________________

FAMILY MEDICAL HISTORY (Please check all that apply for BIOLOGICAL family members) ***PLEASE INDICATE WHO: EX. AUNT, UNCLE, COUSIN***

	MOTHER	FATHER	BROTHERS/SISTERS	MATERNAL GRANDPARENT	PATERNAL GRANDPARENT	MATERNAL SIBLING/FAMILY	PATERNAL SIBLING/FAMILY
ALLERGIES							
ASTHMA							
ECZEMA							
CANCER (TYPE)							
HEART DISEASE							
HIGH CHOLESTEROL							
HIGH BLOOD PRESSURE							
DIABETES							
OBESITY							
GASTROINTESTINAL PROBLEM							
THYROID DISEASE							
PSYCHOLOGICAL PROBLEMS							
ADHD							
MIGRAINES							
SEIZURE DISORDER							
EYE PROBLEMS							
BLEEDING PROBLEMS							
PROBLEMS WITH ANESTHESIA							
OTHER							

I understand copies of the **PATIENTS FINANCIAL RESPONSIBILITY DISCLOSURE, CONSENT FORM, NOTICE OF PRIVACY PRACTICES** and **VACCINE POLICY** are posted on the PALM BEACH PEDIATRICS website and are available in the office. I understand that I am bound by the terms of the policies and failure to do so could result in dismissal.

Signature: ______________________ Relationship to Patient: ______________________

Printed Name: ______________________ Date: ______________________