

CAPITAL PEDIATRIC CARE, INC.
PEDIATRIC PATIENT REGISTRATION
 Ages 17 and Under
 (Please Print)

PATIENT INFORMATION

(Child's Legal Name) Last Name	First Name / MI	Date of Birth	Sex F ___ M ___	Social Security Number
Home Address		City		State Zip Code
Home Phone Number (Child)	Cell Phone Number (Child)	May we leave confidential messages? Y ___ N ___		

MOTHER (Circle One) Birth / Stepmother / Adoptive Mother / Foster-Any custody concerns? Y ___ / N ___ Legal Guardian? Y ___ / N ___

Mother's Full Name Last Name	First Name / MI	Date of Birth	Social Security Number
Home Address		City	
Home Phone Number	Cell Phone Number	Business Phone Number	May we leave confidential messages? Y ___ N ___

FATHER (Circle One) Birth / Stepfather / Adoptive Father / Foster-Any custody concerns? Y ___ / N ___ Legal Guardian? Y ___ / N ___

Father's Full Name Last Name	First Name / MI	Date of Birth	Social Security Number
Home Address		City	
Home Phone Number	Cell Phone Number	Business Phone Number	May we leave confidential messages? Y ___ N ___

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone Number
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PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Insurance Name _____ Policy / ID _____ Group / Plan _____ Insurance Effective Date _____ Policy Holder Name _____ Employer _____ Policy Holder SSN/DOB _____ Relationship to Patient _____	Insurance Name _____ Policy / ID _____ Group / Plan _____ Insurance Effective Date _____ Policy Holder Name _____ Employer _____ Policy Holder SSN/DOB _____ Relationship to Patient _____
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Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, I authorize payment of medical benefits to Capital Primary Care, Inc. or Capital Pediatrics, respectively, for any services furnished me by its physicians. I understand that I am financially responsible for any amount not covered by my insurance.

 Signature of Parent / Guardian / Guarantor

 Date

Acknowledgement of Privacy Practices: I have received notice of the Privacy Practices of Capital Primary Care, Inc. or Capital Pediatrics, respectively, for any services furnished me by its physicians. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agents, information concerning healthcare, advice, treatment and supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

 Signature of Parent / Guardian / Guarantor

 Date

MEDICAL HISTORY FORM

(Please Print)

Today's Date: _____

Name (Last Name First)	Date of Birth	Place of Birth	Occupation	Primary Care Physician
	/ /			

Is this a Referral? Y ___ / N ___ If so, by Whom?	Highest Education	Race	Religious Preference	Organ Donor?

MEDICAL HISTORY: List serious illnesses, injuries, operations, and hospitalizations.

Health Problem	Year	Health Problem	Year

MEDICATION: List medications, including vitamins, over-the-counter drugs, and birth control pills that you take currently.

Medication (dosage, if known)	Medication (dosage, if known)	Medication (dosage, if known)

	Yes	No		Yes	No
Are you allergic to any medications? If so, please list below:			Have you traveled outside the United States within the past 5 years? If so, Where? _____ When? _____		
Are you allergic to any insect bites or stings? If so, please list below:			Are you physically handicapped? If yes, list below.		
Are you aware of any allergies? If so, please list below:			Any religious or cultural restrictions to medical treatment? If so, list below.		
Do you smoke? If so, how much? _____ If not now, have you ever smoked? How much? _____			Do you practice safe sex? (Monogamous relationship / condoms) N/A		
Do you drink alcohol (including beer)? If so, how much per week? _____ If not now, did you ever drink? How much? _____			Do you exercise? If so, how often? _____ What type (list below)?		
Do you use illegal substances? If so, list with frequency below.			Have you ever had an eye exam? If so, when?		
Any psychiatric treatment? If so, when? _____ In or Out Patient treatment? _____			Do you use seatbelts? If so, how often?		
Any known conditions for which you need treatment? If so, list below:			Do you have a Living Will or Advance Directives? If not, would you like more information? Y ___ / N ___		
Have you been treated for any chronic condition? If so, list below:			Identify which mode of learning you prefer. Reading ___ Listening ___ Demonstration ___ Other ___		
Have you ever been exposed to hazardous materials? If so, list below: When? _____ Where? _____			Is there any other health-related info that you wish to share? If so, please list below:		

FAMILY HISTORY: For the family members below, list any hypertension, heart disease, cancer, diabetes, kidney disease, tuberculosis, sickle cell anemia, bleeding tendency, crippling arthritis, alcoholism, suicide or other familial conditions.

MOTHER	
FATHER	
MATERNAL GRANDPARENTS	
PATERNAL GRANDPARENTS	
SIBLINGS	

**FAMILY MEDICINE / INTERNAL MEDICINE
SYSTEMS REVIEW**

Check problems appropriately.

N	P	N		N	P	N	
E	A	O		E	A	O	
V	S	W		R	T	W	
E	S	O		E	S	O	
R	T	W	HAVE YOU EVER HAD:	R	T	W	HAVE YOU EVER HAD:
—	—	—	GENERAL / CONSTITUTIONAL Unexplained weight loss or weight gain Excessive fatigue Prolonged fever / chills Other	—	—	—	FEMALE Method of birth control if sexually active/heterosexual Mid-cycle bleeding Pain with intercourse Vaginal discharge or sores Painful periods Sexually transmitted disease Problem with sexual function Are your periods regular Have you ever been pregnant
—	—	—	HEAD / EYES/ EARS / NOSE / THROAT: Frequent or severe headaches Wear glasses or contact lenses Chronic nasal discharge, drainage or sneezing Impaired hearing When was your last eye exam? Other:	—	—	—	MUSCULOSKELETAL Pain in joints/arthritis Chronic back pain or injury Other:
—	—	—	NEUROLOGICAL: Memory loss Fainting, dizziness, seizures, convulsions Other:	—	—	—	SKIN / BREAST Change or new growth in mole Breast lump Breast nipple discharge Other:
—	—	—	CARDIOVASCULAR Rheumatic Fever Pain or pressure in chest / Angina Any heart trouble Palpitation or pounding heart Abnormal heart rhythm or murmur Swelling of ankles High blood pressure Other:	—	—	—	EMOTIONAL Do you have trouble sleeping Are you often depressed Are you often anxious or nervous Ever had loss of memory Other:
—	—	—	RESPIRATORY Chronic cough Asthma or wheezing Shortness of breath at night Shortness of breath Other:	—	—	—	OPTIONAL Are you sexually active Are you sexually active with members of opposite sex __, same sex __, or both __ If sexually active with the opposite sex, do either of you use contraception (birth control). If so, what form?
—	—	—	GASTROINTESTINAL Abdominal pain Loss of appetite Change in bowel habits (constipation or diarrhea) Noted blood in stool Hemorrhoids or rectal disease Other	—	—	—	HEMATOLOGICAL / LYMPH Anemia Excessive bleeding or abnormal bruising A transfusion Any swelling of lymph nodes Other:
—	—	—	GENITOURINARY Frequent urination at night Frequent painful urination Difficulty stopping or starting urine stream Urinary tract infection	—	—	—	ENDOCRINE Cold or heat intolerance, any thyroid problems Excessive thirst or hunger Other:
—	—	—	MALE Sores or discharge from penis Lump on or pain of testicle Sexually transmitted disease Condom use Problems with sexual function	—	—	—	Reviewed _____ Date _____ Reviewed _____ Date _____ Reviewed _____ Date _____

NAME: _____ DOB: _____ DATE: _____