PEDIATRIC PATIENT INTRODUCTION

Child's Name _____ Mother's Name _____
Last First Middle Last First Middle

Case Number _____ Father's Name _____
Last First Middle

Address: _____City:_____State:____ Zip:_____

Home Phone:_____Mother's Work Phone:_____ Father's Work Phone:_____

Birth Date: _____ Age: _____ Birth Weight: _____ Current Weight: _____

Sex: _____ No. of Siblings:____ Birth Length: _____ Current Length: _____

Type of Birth: Normal Vaginal:_____ Forceps: _____ Breech : _____ Cesarean: _____
Home: _____ Birthing Center: _____ Hospital: _____

Problems During Pregnancy: _____

Problems During Labor/Delivery:_____

APGAR Scores: ___ ___ Was there presence at birth of: ____Juandice(yellow) ____Cyanosis(blue)

Congenital Anomalies / Defects: _____

Infant Feeding: Breast: _____ Bottle: _____ Formula: _____

No. of Hours Sleep Per Night: _____ Quality of Sleep: Good: ____ Fair: ____ Poor: ____

Obstetrician /Midwife: _____
Name Located at

Pediatrician/ Family MD: _____
Name Located at

Date of Last Visit to MD: _____ Purpose: _____

Immunization History: _____

Purpose of this appointment: _____

Has your child been treated on an emergency basis? _____

Describe: _____

Authorization For Care Of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son daughter/ ward.
Signed: _____ Witnessed: _____Date:__-__-__
I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-rays remain the property of this clinic.

Date: _____ Signature: _____