ONSLOW PEDIATRIC ASSOCIATES, P. A.

PATIENT INFORMATION

Patient's Full Name: _____
(Last) (First) (Middle)

Child's Date of Birth: _____ Child's Gender: Male or Female SSN# : _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Primary Phone Number: ( ) - Is this a cellphone: Y or N

Emergency Contact Number: ( ) - Emergency Contact Name: _____

Please circle the best answer to the following questions:

Language of child: English / Spanish / Japanese / Tagalog / Other _____

Ethnicity of child: Unknown / Hispanic or Latino / Not Hispanic or Latino / Decline to Specify

Race of child: American Indian or Alaskan Native / Asian / Black or African-American / Hawaiian Native or Pacific Islander / White / Declined to Specify

Please circle the preferred contact method for each of the following:

Medical Issues: Primary Phone / Cell Phone / Text to Cell Phone / Email

Appointment Reminders: Primary Phone / Cell Phone / Text to Cell Phone / Email

Appointment Recalls: Primary Phone / Cell Phone / Text to Cell Phone / Email

Mother/Guardian's Full Name: _____ Date of Birth: _____

Email: _____ Phone Number: ( ) -

Home Address: _____
(Street) (City) (State) (Zip Code)

SSN#: _____ Language: English / Spanish / Other _____

Employer: _____ Phone Number: ( ) -

Father/Guardian's Full Name: _____ Date of Birth: _____

Email: _____ Phone Number: ( ) -

Home Address: _____
(Street) (City) (State) (Zip Code)

SSN#: _____ Language: English / Spanish / Other _____

Employer: _____ Phone Number: ( ) -

Emergency Contact Name: _____ Phone Number: ( )

INSURANCE INFORMATION

Primary Insurance Name: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Secondary Insurance Name: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

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BIRTH HISTORY

Patient's Name: _____ **D.O.B** _____
(Last) (First)

Where was the patient born? _____ How many weeks at birth? _____

Was a NICU stay required? Y N Explain reason for stay: _____

During pregnancy, did mother use any of the following: Tobacco / Drink Alcohol / Drugs or Medications

If yes, describe what and how long any of the above was used: _____

PAST MEDICAL HISTORY

Has the Patient ever had problems with or been diagnosed with any of the following:

Circle correct answer and explain if needed: (DK = Don't Know)

Any Birth Defects	Y	N	DK	Explain	_____
Genetic Conditions	Y	N	DK	Explain	_____
Thyroid or other Endocrine Disorders	Y	N	DK	Explain	_____
Diabetes	Y	N	DK	Explain	_____
Urologic Problems	Y	N	DK	Explain	_____
Cancer	Y	N	DK	Explain	_____
Frequent Infections / Immune Disorders	Y	N	DK	Explain	_____
GI Disorders	Y	N	DK	Explain	_____
Mental Health Disorders	Y	N	DK	Explain	_____
Neurologic Disorders: ADHD / Seizures / Developmental Delays	Y	N	DK	Explain	_____
Heart Conditions or Heart Murmur	Y	N	DK	Explain	_____
Anemia or Bleeding Disorder	Y	N	DK	Explain	_____
Blood Transfusion	Y	N	DK	Explain	_____
Orthopedic Problems	Y	N	DK	Explain	_____
Serious Injuries or Accidents	Y	N	DK	Explain	_____
Surgeries	Y	N	DK	Explain	_____
Hospitalizations	Y	N	DK	Explain	_____
Nasal Allergies or other Allergies	Y	N	DK	Explain	_____
Respiratory Conditions: Asthma, Bronchitis, Pneumonia	Y	N	DK	Explain	_____
Chronic or Recurrent Skin Problems	Y	N	DK	Explain	_____
Frequent Ear Infections or Sinus Infections	Y	N	DK	Explain	_____
Pharyngitis/Tonsillitis	Y	N	DK	Explain	_____
Frequent Abdominal Pain	Y	N	DK	Explain	_____
Constipation requiring doctor visits	Y	N	DK	Explain	_____
Bed-wetting (after 5 years of age)	Y	N	DK	Explain	_____
Eating Disorders	Y	N	DK	Explain	_____
Special Diet	Y	N	DK	Explain	_____
Nutrient Deficiency	Y	N	DK	Explain	_____
Hearing Problems	Y	N	DK	Explain	_____
Eye Conditions/ Corrective Lenses	Y	N	DK	Explain	_____
Frequent Headaches	Y	N	DK	Explain	_____
If Female, have Menstrual Periods Started	Y	N	DK	Explain	_____
If Female, any problems with Periods	Y	N	DK	Explain	_____
Use of Alcohol or Drugs	Y	N	DK	Explain	_____
Other Significant Problems	Y	N	DK	Explain	_____

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SOCIAL HISTORY

Patient's Name: _____ **D.O.B** _____
(Last) (First)

Please list all those living in the child's home:

Name	Relationship to child	Birth Date	Health Problems

What is the child's living situation if not with both biological parents?

Joint Custody/Single Custody please explain: _____

Lives with Adoptive Parents Y N

Lives with Foster Family Y N

Lives with other Relatives Y N Explain: _____

Any Pets in the home? Y N

Any Smokers in the home? Y N

Any Guns in the home? Y N

If yes, are they locked up and kept separate from the ammunition? Y N

FAMILY MEDICAL HISTORY

Have any family members had the following:

Circle correct answer and state the relationship to patient: Mother, Father, Maternal Grandparents, Paternal Grandparents, Aunt, Uncle

Nasal Allergies or Other Allergies Y N WHO: _____

Asthma/Lung Disease Y N WHO: _____

Heart Disease Y N WHO: _____

High Blood Pressure Y N WHO: _____

High Cholesterol Y N WHO: _____

Diabetes or Other Endocrine Problems Y N WHO: _____

Cancer Y N WHO: _____

Anemia Y N WHO: _____

Bleeding Disorders Y N WHO: _____

Mental Retardation or Developmental Disorders Y N WHO: _____

Neurologic Disorders including ADHD Y N WHO: _____

Liver Disease Y N WHO: _____

GI Conditions Y N WHO: _____

Kidney Disease Y N WHO: _____

Bed-wetting (after 10 years old) Y N WHO: _____

Hearing Impairment Y N WHO: _____

Vision Impairment or Eye Conditions Y N WHO: _____

AIDS/HIV or Recurrent Infections Y N WHO: _____

Alcohol abuse Y N WHO: _____

Drug Abuse Y N WHO: _____

Mental Illness Y N WHO: _____

Tuberculosis Y N WHO: _____

Any additional family conditions Y N WHO: _____