Today's Date:______________

# Meet and Greet

**Parent 1 (Main contact for child)**:

Name: ____________________________________ Date of birth: ___________________

Cell: _________________________________ Home:___________________________

Parent's email: ____________________________________________________________

Employer: _________________________________________________________________

Occupation: _______________________________________________________________

Lives with patient? ☐Yes ☐No Relation to Patient: ___________________

**Parent 2**:

Name: ______________________________ Date of birth: ____________

Cell: ____________________________________________________________________

Parent's email: ___________________________________________________________

Employer: ________________________________________________________________

Occupation: ______________________________________________________________

Lives with patient? ☐Yes ☐No Relation to Patient: ___________________

**Patient's Mailing Address:**

___________________________________________________________________________

(Street ) (City) (State & Zip)

Primary Phone Number: ___________________Is this a cell or home #? _______________

Does it belong to mom or dad? _________________

**If Mother is Pregnant:**

Mother's OB/Gyn:_______________________________________________

Place of Delivery:_______________________________________________

Baby's Expected Due Date: _________________________

Baby's Gender: ________________________

Baby's First Name (if known): ________________________________________

Baby's Last Name: _________________________________________________

**Insurance the child(ren) will be under when patients under our service**

Please give copy of insurance card(s) to front desk

Name of Primary Insurance:_________________________________________

Policy Holder's Name:_____________________________ Policy Holder's Date of Birth:_____________

Mother's Maiden Name:______________________________________

****For parents who may be transferring their children to us from another practice, please answer the following questions for all of your children on back:**

## Children (please list all children in family)

| Name (First and last) | Sex (M/F) | Date of Birth(Mo/Day/Year) |
| --- | --- | --- |
| ____________________ | _____________ | __________________________ |
| ____________________ | _____________ | __________________________ |
| ____________________ | _____________ | __________________________ |
| ____________________ | _____________ | __________________________ |
| ____________________ | _____________ | __________________________ |

**1. Do you believe in vaccinating your children?**_______________________________________________________

**2. Are your children current on their vaccines?**______________________________________________________

**3. Date of last well visit for each of your children:**___________________________________________________

**4. Do any of your children have chronic condition(s), such as diabetes, asthma, or allergies? Y/N**

If yes: which ones? List children's names & condition(s):_______________________________________

_____________________________________________________________________________________________

If yes, is it currently being maintained? _________________________________________________________

5. **Are any of your children seeing a specialist? If so, who?** ___________________________________________

6. **Are any of your children taking medication routinely for any reason? Y/N**
   - If yes: which ones? (write children's names and the name of the medication they are taking):_______________________________________________________________________
   - What are the medications for? ______________________________________________________________

7. **Do any of your children see or have they seen a counselor for any reason? Y/N**
   - If yes: which ones (write children's names):_________________________________________________
   - Please list reason(s) and approximate dates of service: _______________________________________

8. **Have any of your children ever been hospitalized for any reason? Y/N**
   - If yes: which ones (write children's names):_________________________________________________
   - Please list reason(s) and approximate dates of service: _______________________________________

9. **Any other medical or other information you would like the doctor or our practice to be aware of?**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**In order for us to best care for your child, our office requires your child's medical records to be sent to us and reviewed before any appointment can be scheduled. It is extremely important to have an up to date immunization record, accurate growth charts, and up to date documentation of any chronic conditions. These records can be sent to us via mail, fax, or email. You can also obtain the records yourself and give us a copy.**

**Name of person filling out this form (print):**_______________________________________________

**Signature:**_____________________________________________________________________________