

Meet and Greet/New Patient Registration Form

Date: _____

****Please fill out this entire form ***in full***. Any missing information may cause a delay in scheduling an appointment for your child with our office.

Parent 1 (Main contact for child)

Relation to Patient(s):

Name: _____ Date of birth: _____

Cell Phone: _____ Home Phone: _____

Parent's email: _____

Employer: _____

Occupation: _____

Lives with patient? Yes No Address if different from patient or other parent:

(Street) (Apartment #) (City) (State & Zip)

Parent 2

Relation to Patient(s):

Name: _____ Date of birth: _____

Cell Phone: _____ Home Phone: _____

Parent's email: _____

Employer: _____

Occupation: _____

Lives with patient? Yes No Address if different from patient or other parent:

(Street) (Apartment #) (City) (State & Zip)

Patient's Mailing Address:

(Street) (Apartment #) (City) (State & Zip)

Primary Phone Number: _____ Is this a cell or home #? _____

Does it belong to mom or dad? _____

Secondary Phone Number (required): _____ Is this a cell or home #? _____

Who does it belong to? _____

Children (please list all children in family that will be coming to our office for care)

<u>Name (First and last)</u>	<u>Gender (M/F)</u>	<u>Date of Birth (Mo/Day/Year)</u>
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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If Mother is Pregnant:

Mother's OB/Gyn: _____

Place of Delivery: _____

Baby's Expected Due Date: _____ Baby's Gender (if known): _____

Baby's First Name (if known): _____

Baby's Last Name: _____

Insurance the child(ren) will be covered under while attending our office for care:

****** Please give copy of your insurance card(s) and photo ID to the front desk******

Name of Primary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's SSN (**required** if you would like us to bill your insurance company on your behalf): _____

Insurance ID#: _____ Insurance Group#: _____

Mother's Maiden Name (some insurance companies and hospitals require this): _____

Health History: please answer the following questions for all of your children:

1. Do you believe in vaccinating your children? _____

2. Are your children current on their vaccines? _____

3. Approximate date of last well visit for each of your children (month & year): _____

4. Do any of your children have any chronic condition(s) such as diabetes, asthma, or allergies? Y/N
If yes, list children's names & condition(s): _____

5. Are any of your children seeing a specialist? Please list children's names, provider's name, reason, and approximate dates of service: _____

6. Are any of your children taking medication routinely for any reason? Y/N
Please list children's names, the name of the medication they are taking, and what the medication is for:

7. Do any of your children see or have they seen a therapist or counselor for any reason? Y/N
Please list children's names, provider's name, reason, and approximate dates of service: _____

8. Have any of your children ever been hospitalized for any reason? Y/N
Please list children's names, reason, and approximate date(s): _____

9. Any other information (medical or otherwise) that you would like 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. If you need help obtaining your records, contact us and we will be happy to assist.

Name of person filling out this form (print): _____

Signature: _____ **Relation to patient:** _____