Health Professionals of Winfield

Pediatrics

Patient First Name	Middle Name	Last Name
Date of Birth		Social Security Number

Gender: Male Female	Race	
Preferred Contact Method: Email Phone Postal Patient Portal	Appointment Notification Contact Method: Email Call: Primary Cell Work	Email

Street Address	City	State	Zip

Primary Phone #, name and relationship	Work Phone #, name, and relationship	Mobile/Other Phone #, name and relationship

Emergency Contact Last Name, First Name	Relationship	Phone #

Guarantor Name		Patient's Relationship to Guarantor
Date Of Birth	Social Security #	Address
Primary Phone #	Work Phone #	Employer

Employer	Occupation	City, State, ZIP

Insurance Information	Secondary Insurance Name
Insurance Company:	Insurance Company:
Policy #:	Policy #
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Please Check here if NO Insurance:	Please Check here if NO Insurance:

Patient Name:	DOB:

PERSONAL MEDICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

ADHD	Behavior Problems	Learning Disabilities	
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Seizure Disorder
Anxiety	Eczema	Liver Disease	Thyroid Disorder
Asthma	GERD	Crohn's Disease	
Bladder Problems	Heart Disease	High Cholesterol	
Constipation	Hernia		**Other not listed:**
Headaches	Umbilical Hernia		
Kidney Disease	High Blood Pressure		

Allergies:

Drugs:
Food
Other: (bees, pets, etc.)

Gestational weeks	
Birth weight and length	
Are immunizations up to date?	
Method of delivery	
Diet (breast or formula)	

Patient Name	DOB

SURGICAL HISTORY: PLEASE LIST ALL PRIOR SURGERIES AND APPROXIMATE DATES PERFORMED:

Surgery	Date

HOSPITAL ADMISSIONS OR RECENT EMERGENCY ROOM VISITS THIS YEAR: Month / Year

SOCIAL HISTORY

13 + Years	Frequency
Tobacco Use	
Alcohol Use	
Drug Use	
Caffeine	
Exercise	

Medication	Dosage	Frequency

Patient Name:	DOB:

Preferred Pharmacy:

Pharmacy Name:	Address	Phone Number

CULTURAL HISTORY:

Elementary	High School			

Do you have any vision problems that affect your communication? Yes or No

Do you have hearing problems that affect your communication? Yes or No

Do you have any limitations to understanding and / or following instructions? Yes or No

Who does the child live with:

Who lives in the home:

Any secondhand smoke exposer?

List any family medical history:

Family History	Mother	Father	Siblings	Grandparents
Asthma				
Allergies				
Diabetes				
Heart Issues				
Other:				

Patient Name:	**DOB:**

Authorization to release information:
I authorize for information regarding my medical care to be released to the following person(s) if he or she so requests:

Name	Relationship to patient	Phone number

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any information required for claim(s) submission to my insurance company(s). I also authorize those payments be made directly to Health Professionals of Winfield.

Signature: _____ Date: _____

Parent, if minor: _____ Date: _____