

Patient Registration

Cell Phone Parent 1: _____

Date _____

(Please Print)

Cell Phone Parent 2: _____

Patient's Name (Last, First, MI) Birth Date (MM/DD/YYYY) Age

Street Address City State Zip

Male Female

Home Phone Social Security #

Do other family members receive care in this office? Yes / No If yes, Name(s) _____

Name of Parent/Guardian #1 Relationship to Patient

Street Address (if different) City State Zip

Birth Date (MM/DD/YYYY) Social Security Home Phone (if different)

Occupation Employed by Work Phone

Work Street Address City State Zip

Name of Parent/Guardian #2 Relationship to Patient

Street Address (if different) City State Zip

Birth Date (MM/DD/YYYY) Social Security Home Phone (if different)

Occupation Employed by Work Phone

Work Street Address City State Zip

WHO TO CONTACT IF WE CAN'T REACH PARENT/GUARDIAN IN AN EMERGENCY?

Name Relationship to Patient Home Phone

Street Address City State Zip

INSURANCE INFORMATION

Name of Primary Insurance Carrier Name of Policy Holder

Insurance Identification Number Group Number

Street Address City State Zip

Name of Secondary Insurance Carrier (if any) Name of Policy Holder

Insurance Identification Number Group Number

Street Address City State Zip

The guarantor is responsible for all fees. Fees are due at the time of service.

Please read and sign the following Authorization and Assignment.

Insurance Authorization & Assignment

I hereby authorize **Ofelia B. Ayuste, M.D. S.C.** to furnish information to my insurance company carrier concerning my child or children's illness or treatment. I also hereby assign the Doctor all outstanding payments for medical services rendered to my dependent(s). I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Insured/ Parent's Signature: _____

A photocopy of this Authorization shall be considered as valid as the original

Family History

Have any family members had the following:

- | | | | | |
|---|------------------------------|-----------------------------|-----------|----------------|
| Deafness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Heart disease (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High blood pressure (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bleeding disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Diabetes (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Epilepsy or convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Alcohol abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Drug abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental retardation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |

Additional family history _____

Past History

Does your child have, or has he/she ever had:

- | | | | |
|---|------------------------------|-----------------------------|---------------|
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Frequent ear infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with ears or hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with eyes or vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any heart problem or heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Anemia or bleeding problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Constipation requiring doctor visits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bladder or kidney infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bed-wetting (after 5 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| (For girls) Has she started her menstrual periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| (For girls) Are there problems with her periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any chronic or recurrent skin problem (acne, eczema, etc) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Convulsions or other neurologic problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Thyroid or other endocrine problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any other significant problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Use of alcohol or drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____

DATE COMPLETED _____

BIRTH DATE _____ AGE _____

M F

Household

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

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the delivery Vaginal? Cesarean?

Was the baby born at term? _____ Early? _____ Late? _____

If cesarean, why? _____

If early, how many weeks' gestation? _____

Did your baby have any problems right after birth?

Did mother have any illness or problem with her pregnancy?
 Yes No Explain _____

Yes No Explain _____

During pregnancy, did mother
 Smoke Yes No Drink alcohol Yes No
 Use drugs or medications Yes No
 What _____ When _____

Was initial feeding Breast? Bottle?

Did your baby go home with mother from the hospital?
 Yes No Explain _____

General

Do you consider your child to be in good health? Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? Yes No Explain _____

Has your child had any surgery? Yes No Explain _____

Has your child ever been hospitalized? Yes No Explain _____

Is your child allergic to any medicines or drugs? Yes No Explain _____

Development

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

