PEDIATRIC PATIENT INTAKE FORM

Welcome to Healey Medical Practice**!** We are pleased to serve your health care needs and those of your family. In order to assist our providers and staff, please fill in the information below to the best of your ability.

Patient Name: _____ Sex: M F Date of Birth: ___/___/____ SS# _____

Address _____
Street City/Town State Zip Code

Home Phone: _____Cell Phone:_____ Social Security # _____

Insurance Carrier: _____ Policy Holder's Name:_____

Policy Number:_____Your relation to Policy Holder:_____Policy Holder SS#:_____

I agree to allow Healey Medical Practice to send a bill for treatment(s) to my insurance carrier:

Patient/Guardian signature: _____ Date: ___/____/_____

PARENT/GUARDIAN INFORMATION:

_____
Mother's Name Address (If different) Phone #

_____
Father's Name Address (If different) Phone #

If different than above, please list below who is the Legal Guardian for this child/patient:

_____(___)_____
Name Relationship Address (If different) Phone number

_____(____)_____
Name Relationship Address (If different) Phone number

Please explain any special circumstances regarding custody and parties involved in medical decision making:

_____

_____

_____

Former Primary Care Provider _____(____)_____
Name Address Phone number

Please list below any specialists you see/have seen, contact information if possible:

_____

_____

HEALTH MAINTENANCE HISTORY (Please indicate date of last exam/test)

Exam	Date	Exam	Date
Routine Physical		Dental Exam	
Lead Test		Eye Exam	

Patient Name:_____ **Date of Birth:** ___/____/_____

PAST MEDICAL HISTORY **Check one for each box…..Yes or No**

Condition	Y	N	Condition	Y	N	Condition	Y	N
ADHD			Fractures			Scoliosis		
Allergies			Intestinal Disorder			Seizure Disorder		
Asthma			Joint Disorder			Thyroid Disorder		
Acne			Kidney/Urinary Disease			**List others below:**		
Chicken Pox			Liver Disease					
Ear Infections			Meningitis					
Developmental Problems			Mental Illness					
Diabetes			Mononucleosis					
Eczema			Neurologic Disorder					
Eye Disease			Reflux					

Please provide any additional details regarding those condition(s) above where you marked "yes":

_____

_____

_____

_____

Birth History

Full Term____ Premature_____ Number of weeks _____ Type of Delivery _____

Pregnancy Complications _____ None___ Delivery Complications_____ None____

Jaundice - Yes___ No___ Hearing Test - Pass ___ Fail ___ Birth Weight: _____ Birth Length:_____

Received Hepatitis B vaccine in hospital? Yes ___ No___

Allergies **(include reaction):**

_____

_____

_____

Medications **(Includes birth control, over the counter, vitamins, supplements, and herbal remedies):**

Name Dose Frequency Reason For Use

_____

_____

_____

Surgeries

Year Procedure Surgeon Facility

_____

Patient Name:_____ **Date of Birth:** ___/____/_____

Hospitalizations

Year Reason Facility (Name and address if out of local area)

_____

_____

_____

_____

Personal Background

Current Grade Level _____ School _____

Special Needs/Services_____ None _____

Extracurricular Activities _____

Age of onset menstrual periods _____ Frequency _____ Duration ____

Family History

Adopted ___ Unknown ___ Please list below any pertinent medical illnesses in the patient's family.

Father _____Mother_____

Brother(s) _____ Sister(s) _____

_____ _____

Paternal Grandfather_____ Paternal Grandmother_____

Maternal Grandfather _____ Maternal Grandmother_____

Additional Family Members – not listed above:

_____

This Pediatric Intake Form has been completed to the best of my ability -

Signature of Parent/Guardian:_____ **Date: ___/____/_____**