NEWBORN INTAKE

NAME_____

DATE OF BIRTH_____

HOSPITAL_____ OBSTETRICIAN_____

GESTATIONAL AGE AT DELIVERY_____DELIVERY VAG / C-SEC / VBAC

COMPLICATIONS_____

BIRTH WEIGHT_____BIRTH LENGTH_____

DISCHARGE WEIGHT_____

APGAR_____

OAE_____

GBS_____

BREAST / FORMULA _____

BABY'S BLOOD TYPE/Rh_____

MOTHER'S BLOOD TYPE/Rh_____

FAMILY HISTORY

MOTHER NAME_____ AGE_____

MEDICAL HISTORY_____

FATHER NAME_____ AGE_____

MEDICAL HISTORY_____

SIBLING NAME AGE SIGNIFICANT MEDICAL HISTORY

_____

_____

_____

Prevention/Anticipatory Care

Do you use seatbelts / car seats for family members? Yes / No

Do you use bicycle helmets? Yes / No

Are there smokers in your home? Yes / No

Is there a smoke environment at the caretakers (daycare/babysitter)? Yes / No

Is there a gun/weapon in your home? Yes / No Is it properly stored? Yes / No

Do you use drugs? (illicit/illegal) Yes / No

Have you or your spouse engaged in activities that put you at risk for HIV? Yes / No

Do you have smoke detectors in your home? Yes / No

Do you have carbon monoxide detectors in your home? Yes / No

Do you have medication/chemicals properly stored? Yes / No

Do you use skin protectors (sun block) from UV light? Yes / No

Do you have Poison Control Telephone number at home? Yes / No

POISON CONTROL <1-800-222-1222>

NOTCHVIEW PEDIATRICS, LLC

DEMOGRAPHIC/INSURANCE INFORMATION/FINANCIAL POLICY

PATIENT NAME_____

DATE OF BIRTH_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

TELEPHONE_____CELL TELEPHONE_____

WORK TELEPHONE_____ EMAIL_____

EMERGENCY NAME AND CONTACT NUMBER _____

PHARMACY NAME AND TELEPHONE _____

GUARANTOR (RESPONSIBLE PARTY) INFORMATION

NAME_____RELATIONSHIP TO PATIENT_____

GUARANTOR ADDRESS_____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

MOTHER'S NAME_____ DATE OF BIRTH _____
SOCIAL SECURITY NO._____

FATHER'S NAME_____ DATE OF BIRTH_____
SOCIAL SECURITY NO._____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID # _____

SUBSCRIBER_____ SUBSCRIBER DOB_____

INSURANCE COMPANY ADDRESS_____

_____

TELEPHONE _____ EFFECTIVE DATE _____

SECONDARY INSURANCE _____ ID # _____

SUBSCRIBER _____ SUBSCRIBER DOB_____

INSURANCE COMPANY ADDRESS _____

_____

TELEPHONE_____ EFFECTIVE DATE _____

PLEASE READ AND SIGN THE FINANCIAL AGREEMENT/MEDICAL RELEASE POLICY ON REVERSE

4/23/12