NOTCHVIEW PEDIATRICS, LLC DATE____________

NEW PATIENT INTAKE

NAME____

DATE OF BIRTH____ SEX: M / F

MOTHER'S NAME_______________________ FATHER'S NAME_______________________

WHOM SHALL WE THANK FOR THIS REFERRAL___________________________________

PREVIOUS PRIMARY CARE PHYSICIAN

____

SIGNIFICANT DIAGNOSES YOUR CHILD HAS:

____

____

____

DOES YOUR CHILD HAVE ANY ALLERGIES (INCLUDING SEASONAL, FOOD, MEDICATION, ETC.)?

____

____

____

____

PLEASE LIST ANY SPECIALISTS YOUR CHILD MAY BE FOLLOWED BY

NAME	TYPE OF SPECIALTY	CITY	PHONE

PLEASE LIST ANY THERAPISTS YOUR CHILD MAY BE FOLLOWED BY (SPEECH, OCCUPATIONAL, PSYCHOLOGIC COUNSELORS,ETC)

NAME	TYPE OF THERAPY	CITY	PHONE

IS YOUR CHILD IMMUNIZED/VACCINATED? YES / NO

ARE YOUR CHILD'S VACCINES/IMMUNIZATIONS UP TO DATE? YES / NO

IF IMMUNIZED HAS YOUR CHILD HAD ANY SIGNIFICANT REACTIONS TO ANY VACCINES? (HIGH FEVER, EXCESSIVE CRYING, RASHES, EXCESSIVE IRRATIBILITY, LOCAL REACTIONS)

VACCINE DATE REACTION

____

____

____

____

MEDICATIONS

PLESE LIST ALL MEDICATIONS INCLUDING VITAMIN SUPPLEMENTS YOUR CHILD IS TAKING

____

____

____

____

____

FAMILY HISTORY

PLEASE LIST ANY SIGNIFICANT MEDICAL HISTORY FOR

MOTHER________________________________

FATHER________________________________

OCCUPATIONS______________________________

SIBLINGS

____

____

____

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