

PARADISE PEDIATRICS, P.C.

Child's name _____

Last, First and Middle Initial

Sex _____ Age _____ Birthdate _____ Nickname _____

Father _____ Home# _____ Work# _____

Mother _____ Home# _____ Work# _____

Home Address _____

Street, Apt.#, City, State and Zip

Name of Responsible party _____

Social Security # _____ Employer _____

Insurance Carrier _____ Effective Date _____

ID # _____ Group# _____

In An Emergency Notify _____

Do we see any other family members? _____ Who referred you to our office? _____

Has child had any history or difficulty with any of the following (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Bleeding, excessive | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pneumonia |

FAMILY HISTORY

Has any member of the family or close relative had (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia-Bleeder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Convulsion or Epilepsy | <input type="checkbox"/> Kidney Disease | _____ |

BIRTH HISTORY

Obstetrician _____ Hospital _____

Type of Delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Date _____

Did baby have problems at or immediately after birth? _____

RELEASE AND ASSIGNMENT

The information that I have given is correct and to the best of my knowledge. I understand that it will be held in confidence and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with _____

and assign directly to Paradise Pediatrics, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize Paradise Pediatrics, P.C. to release all information necessary to secure the payment of benefits

I authorize the use of my signature on this document as binding whether manual or electronic.

_____ Date _____

Signature of Parent/Guardian