



Patient Registration Form

Patient Legal Name: _____
Last Name First Name Middle Initial

Address: _____
Street or Box City Zip Code

Phone: (Primary) _____ (Cell) _____ (Work) _____

Driver's License #: _____ DOB: _____

Email: _____

Spouse Name: _____ DOB: _____

Gender: Male Female SS#: _____

Marital Status: Single Married Life Partner Legally Separated
 Divorced Widow/Widower Unknown

Employment Status: Full Time Part time Employer: _____

Student: Full Time Part time N/A School: _____

Race: American-Indian or Alaska-Native White Asian Native Hawaiian
 Black or African-American More than One Race

Ethnicity: Hispanic or Latino Not Hispanic or Latino Language Spoken: _____

Religion: _____ Referred By: _____

Insurance: _____ Patient Insurance ID Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Emergency Contact Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Name of Preferred Local Pharmacy: _____ Telephone: _____

Pharmacy Address: _____

Mail Order Pharmacy: _____

How do you prefer to receive communications from our clinics (check all that apply):

Phone Call Text Patient Portal/Email Letter

Primary Care Physician: _____ Telephone: _____

Please complete if PATIENT is a student or minor:

Mother's Name: _____ DOB: _____ SS#: _____

Address: _____ Phone: _____

Father's Name: _____ DOB: _____ SS#: _____

Address: _____ Phone: _____

St. Joseph's Pediatric Clinic
Health information form
School Age

Name: _____ Date of birth: _____ Age: _____

Birth History:

Age of mother at birth: _____ Number of mother's pregnancies: _____
Place of birth: _____ Due date: _____
Type of delivery (circle one): VAGINAL or C-SECTION; was labor "induced": YES NO
Baby's birth weight: _____ pounds, _____ ounces

Infant/Child Medical history:

Immunizations current: YES NO List any known drug allergies: _____
Any chronic medical problems (circle all that apply)? NONE or anemia, ear infections, vision problems
Hearing problems, seizures/epilepsy, bladder/kidney infections, pneumonia, bronchitis, allergies,
Asthma, eczema, lead exposure, ADD/ADHD, other _____
Does your child take any medications routinely? YES NO if yes, please list _____

List any surgeries, fractures or injuries: _____

Has your child ever had to be hospitalized? YES NO if yes, please explain: _____

Has your child had any developmental problems? YES NO if yes, please explain: _____

Family history:

(CHECK ALL THAT APPLY)

	Mom	Dad	Siblings	Aunts	Uncles	Grandmothers		Grandfathers	
						Mom's Family	Dad's Family	Mom's Family	Dad's Family
Anemia/Blood disorder									
Heart disease									
High cholesterol									
High blood pressure									
Stroke									
Cancer									
Diabetes									
Epilepsy/seizures									
Kidney problems									
Genetic diseases/birth defects									
Childhood hearing Problems									
TB/tuberculosis									
Asthma/Allergies									

Social history:

Who lives at home currently: _____

List any pets: _____ Does anyone smoke at home? YES NO

Does your child attend school? YES NO, if so what is his/her grade level? _____

Has your child had to repeat a grade? YES NO, if so what grade level? _____

Does your child participate in special educational programs? _____

What out of school activities does your child participate in? _____

Non- Parent/Guardian Authorization for Consent to Medical Care and Treatment

I, _____, the parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named person(s) to consent to the medical care and treatment of my child(ren). I hereby authorized and grant that the below named person(s) has/have permission from the natural parent or legal guardian to sign for any and all medical procedures or treatments deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have the authority to consent for all medical care and treatment of said child(ren).

This authorization is for:

- Today's date only.
- A specific date of: _____.
- All future visits effective for one year from today's date.

I realize that it is my duty to update and notify my physician's office of any necessary changes that must be made to this document within a timely manner. I also understand that to ensure this document is accurate I will be required to complete it annually.

Signature

Relationship to child(ren)

Date

Child(ren):

Name

Name

Name

Name

Name

Name

Person(s) who are authorized to seek medical care for the child(ren) listed above:

Name

Relationship to the child(ren)

Name

Relationship to the child(ren)

Name

Relationship to the child(ren)