Raybon Pediatrics

700 Zeagler Dr., Ste 7
Ph: 386-385-8137/Fax: 386-487-2113

Child 1: Last Name: _____ First Name: _____ MI: _____
D.O.B.: MM / DD / YYYY Sex: _____ Primary Language: _____
Ethnicity: Choose Ethnicity Race: Choose Race
Social Security Number: _____-_____-_____

Insurance Information

Primary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Sex: Choose Sex
Insurance Carrier: _____ Policy ID#: _____
Group #:_____
Secondary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____
Insurance Carrier: _____ Policy ID#: _____
Group #:_____

Child 2: Last Name: _____ First Name: _____ MI: _____
D.O.B.: MM / DD / YYYY Sex: _____ Primary Language: _____
Ethnicity: Choose Ethnicity Race: Choose Race
Social Security Number: _____-_____-_____

Insurance Information

Primary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Sex: Choose Sex
Insurance Carrier: _____ Policy ID#: _____
Group #:_____
Secondary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____
Insurance Carrier: _____ Policy ID#: _____
Group #:_____

Child 3: Last Name: _____ First Name: _____ MI: _____
D.O.B.: MM / DD / YYYY Sex: _____ Primary Language: _____
Ethnicity: Choose Entnicity Race: Choose Race
Social Security Number: _____-_____-_____

Insurance Information

Primary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Sex: Choose Sex
Insurance Carrier: _____ Policy ID#: _____
Group #:_____
Secondary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____
Insurance Carrier: _____ Policy ID#: _____
Group #:_____

Mailing Address: _____
(Street or PO Box) (City) (State & Zip)
Home Phone: (_____) _____ - _____
Who lives at this household? _____
(Please note, this information is being requested to improve intake of your child's Social History.)

Contact Information

Contact 1: Name: _____ Date of Birth: MM / DD / YYYY

Lives with patient? Choose If no, please list contact's address: _____

Contact's phone #: _____(xxx) xxx-xxx_____ Cell Work Home

Social Security Number: _____-_____-_____

Relation to Patient: _____ Biological Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Home or Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home Email Work Email

How would this contact ideally prefer to be contacted regarding:

Medical Issues: Choose One

Appointment Reminders: Choose One

Recall Notices: Choose One

General Practice Notices: Choose One

Patient Portal Notifications: Choose One

Contact 2: Name: _____ Date of Birth: MM / DD / YYYY

Lives with patient? Choose If no, please list contact's address: _____

and Contact's phone #: _____(xxx) xxx-xxx_____ Cell Work Home

Social Security Number: _____-_____-_____

Relation to Patient: _____ Biological Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Home or Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home Email Work Email

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Choose One

Appointment Reminders: Choose One

Recall Notices: Choose One

General Practice Notices: Choose One

Patient Portal Notifications: Choose One

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ Phone: (___) _____ - _____

2: _____ Relationship _____ Phone: (___) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Choose

If no, list who may have access:_____

*****If parents are divorced or separated please fill out this section:**

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Choose

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Patient History Information

If completing for more than 1 child, please indicate which child for each item

Completed by: _____ Date Completed: _____

Does your child have any on-going medical issues?

1. _____
(Diagnosis) (Date)
Details: _____

2. _____
(Diagnosis) (Date)
Details: _____

3. _____
(Diagnosis) (Date)
Details: _____

Has your child ever been Diagnosed with any of these: (please indicate which child & when)

Yes		when/who
	Allergies	
	Anemia/Sickle Trait	
	Asthma	
	Bleeding disorder	
	Bedwetting >10 y/o	
	Cancer	
	Cystic Fibrosis	
	Developmental Delay	
	Diabetes, Childhood	
	Ear Problems	
	Eczema/Skin probs	

Yes		when/who
	Epilepsy/Seizures	
	Genetic Disorder	
	Heart Dz <55 y/o	
	Hi Cholesterol/Trigs	
	Immune Probs, HIV	
	Kidney Disease	
	Liver Disease	
	Mental: Depression/ ADHD/ Bipolar, etc	
	Migraines/headaches	
	Stomach/GI prob	
	*OTHER	

Allergy / Reaction Information

Medication Allergies: No: _____ Yes: ____ (explain below)

1: _____
(Medication) (Reaction) (Age)

2: _____
(Medication) (Reaction) (Age)

Non-Medication Allergies: None: ___ Yes (please list):_____

Vaccine Reactions: None: ___ Yes (please list): _____

Surgeries?

No: Yes:

Pertinent Past Medical History

(if Yes then provide details <u>including age, year or date</u>)

When & Why:

No Yes **Serious Injuries** Please list, with dates:

No Yes **Hospitalizations** When & Why:

Specialists your child has seen (name, office location, when/why):

Current/On-going Medications

1. _____
(Medication) (Dose) (Date Started) (Child's Name)
2. _____
(Medication) (Dose) (Date Started) (Child's Name)
3. _____
(Medication) (Dose) (Date Started) (Child's Name)
4. _____
(Medication) (Dose) (Date Started) (Child's Name)

Pertinent Family Medical History: Does anyone on mother's or father's side have a history of:
{MGM=grandmother-mom's side; PGF=grandfather-dad's side; MGGM- great grandmother-mom's side), etc}

Y	N		relationship
		Addictions	
		Allergies	
		Anemia/Sickle Trait	
		Asthma	
		Bleeding disorder	
		Bedwetting >10 y/o	
		Cancer	
		Cystic Fibrosis	
		Developmental Delay/CP	
		Diabetes, Childhood	

Y	N		relationship
		Diabetes, Adult	
		Epilepsy/Seizures	
		Hearing Loss, childhood	
		Hi Blood Pressure	
		Hi Cholesterol/Trigs	
		Immune Probs, HIV	
		Kidney Disease	
		Liver Disease	
		Depression/ ADHD/ Bipolar, etc	
		Migraine headache	

Other: _____

Pertinent Social History: Does anyone in your home smoke: Y N Do they smoke inside the home: Y N
Any Pets: Y N If yes, what kind? _____
Are both biological parents involved in child's life? _____

Name of Previous Physician, so we can request records: _____

How did you hear about Raybon Pediatrics? _____

Preferred Pharmacy:_____

6-4-2018