PECAN TREE PEDIATRICS

Pediatric New Patient Intake Form

Date: _____

Patient Information

Last Name: _____ First Name: _____ Date of Birth: _____

Primary Phone: _____ Alternate Phone: _____

Primary Address _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ Phone: _____

Preferred Pharmacy's Address: _____

Parent/Guardian Information

#1 Last Name: _____ First Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____ Type: ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Deceased

Phone: _____ E-mail: _____

☐ Address Same as Patient

Address _____ City: _____ State: _____ Zip: _____

Does patient reside with this parent/guardian? ☐Yes ☐No Rights to patient: ☐ Exclusive Custody ☐ Joint Custody ☐ Other _____

**Please provide court documents (for patient medical records files) pertaining to the patient's medical rights/restrictions if necessary*

#2 Last Name: _____ First Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____ Type: ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Deceased

Phone: _____ E-mail: _____

☐ Address Same as Patient

Address _____ City: _____ State: _____ Zip: _____

Does patient reside with this parent/guardian? ☐Yes ☐No Rights to patient: ☐ Exclusive Custody ☐ Joint Custody ☐ Other _____

**Please provide court documents (for patient medical records files) pertaining to the patient's medical rights/restrictions if necessary*

Medical Insurance

Primary Insurance Payor: _____ Subscriber ID: _____ Group #: _____

Policy Holder/Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Payor: _____ Subscriber ID: _____ Group #: _____

Policy Holder/Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Authorized Individuals for Patient Care and Accompaniment/Consent for Treatment

Please provide the names of any individuals (such as grandparents, babysitters, family friends, or other caregivers) whom you authorize to bring your child to medical appointments, receive medical information and/or prescriptions, and consent to routine medical care or immunizations on your behalf when you are unable to attend.

Authorized Individual Full Name	Relationship to Patient	Phone

Parent/Legal Guardian Authorization:

I acknowledge that the information provided on this intake form is accurate and complete to the best of my knowledge. I consent to the provision of routine medical care and treatment for my child and understand that I am responsible for notifying the practice of any changes to the information provided.

I further authorize the individuals listed in the section "Authorized Individuals for Patient Care and Accompaniment/Consent for Treatment" to accompany my child to appointments, receive relevant medical information and prescriptions, and consent to routine medical care and immunizations on my behalf when I am unable to attend.

By signing below, I acknowledge and agree to these terms. I certify that I am the parent or legal guardian of the patient listed above.

Parent or Legal Guardian Name (Print): _____ Relationship to Patient: _____

Parent or Legal Guardian Signature: _____ Date: _____

Last Name: _____ First Name: _____ DOB: _____

Patient's Medical and Social History

Birth History

Is the patient adopted? ☐ Yes ☐ No If yes, is patient aware that he or she is adopted? ☐ Yes ☐ No

Birth weight: _____ Weeks of gestation at birth: _____ Delivery: ☐ C-Section ☐ Vaginal Delivery ☐ Vacuum ☐ Forceps

If C-Section, why? _____

Group B Strep (GBS)+: ☐ Yes ☐ No ☐ Unknown

Was patient placed in NICU or Special Care Nursery: ☐ Yes ☐ No If "Yes", please give details: _____

During pregnancy, did the biological mother use: ☐ Tobacco ☐ Alcohol ☐ Illicit drugs ☐ Prenatal vitamins

Please describe any health problems the mother or patient experienced during pregnancy, during labor, during delivery or after birth: _____

Medical History

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? ☐ Yes ☐ No

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis).

Allergy	Reaction		Allergy	Reaction

Please list ALL current medications, including over-the-counter supplements and herbs.

Medication Name/Strength	Dose		Medication Name/Strength	Dose

Please list any past surgeries and hospitalizations and the approximate date.

Surgeries/Procedure/Hospitalization	Date	Reason	Complications

Last Name: _____ First Name: _____ DOB: _____

Patient's Medical and Social History (Continued)

Has the patient EVER had any of the following?

ADD/ADHD	☐ Yes ☐ No		Endocrinology/Growth disorder/problems	☐ Yes ☐ No
Allergies (seasonal)	☐ Yes ☐ No		Gastrointestinal (stomach/bowel/liver) problems	☐ Yes ☐ No
Anemia/Bleeding tendency	☐ Yes ☐ No		Genitourinary (Kidney & Bladder) disorder	☐ Yes ☐ No
Asthma/Breathing Problems	☐ Yes ☐ No		Immune Deficiency	☐ Yes ☐ No
Autism	☐ Yes ☐ No		Neurological (seizure or epilepsy)	☐ Yes ☐ No
Bed-wetting	☐ Yes ☐ No		Orthopedic problems (fractures, etc)	☐ Yes ☐ No
Cancer	☐ Yes ☐ No		Psychiatric problems (depression, anxiety, etc)	☐ Yes ☐ No
Cardiovascular/Heart disorders/problems	☐ Yes ☐ No		Rheumatological (muscle, bones, joints, tendons, etc) disease/disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No		Thyroid disorder	☐ Yes ☐ No
Ears/Nose/Throat problems	☐ Yes ☐ No		OTHER:	☐ Yes ☐ No
Eczema/Skin disorder	☐ Yes ☐ No		OTHER:	☐ Yes ☐ No
Eye disorder/Vision Impairment	☐ Yes ☐ No		OTHER:	

Please list any other medical illnesses or problems not listed above and provide details for any of the above conditions: _____

_____

_____

For females only: Have you started menstruating? ☐ Yes ☐ No If yes, at what age did you start? _____

Social History

Please provide details of siblings and other individuals in the household:

Name	DOB	Gender	Relationship to Patient	Type (if sibling)	Lives with Patient (FT): Full-time, (PT) Part-time
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody

Custody/Household Status:

Parents/Guardians: ☐ Together ☐ Separated ☐ Divorced ☐ Never Married ☐ Other: _____

Custody arrangement: ☐ 50/50 shared custody ☐ Primary w/Mother ☐ Primary w/Father ☐ Other: _____

Does the patient regularly live in two households? ☐ Yes ☐ No

If yes, please list siblings/other children present in each household:

Household 1: _____ Household 2: _____

Please describe the patient's current living/custody arrangement, including all households in which the patient regularly resides: _____

_____

Exposure History

Does patient attend daycare? ☐ Yes ☐ No Does anyone who lives in same home as patient smoke? ☐ Yes ☐ No If yes, who? _____

Do you have any pets? ☐ Yes ☐ No If yes, how many? _____ What type(s)? _____

If guns in home: **Pecan Tree Pediatrics recommends that guns be locked up and kept separate from ammunition**

Pool/Bodies of Water: If your home has a pool or body of water nearby, is it/are they surrounded by a 4-sided fence or other precaution to keep your child safe from accidental drowning? ☐ Yes ☐ No ☐ We do not have a pool or body of water near our home. **Pecan Tree Pediatrics recommend that bodies of water near the home be surrounded by a 4-sided fence and direct supervision of children around these bodies of water/pool areas. **

Family Medical History

Please indicate any major conditions/illnesses that the patient's immediate family members have had.

M-mom, **D**-dad, **B**-brother, **S**-sister
MGM-mom's mom, **MGF**-mom's dad, **MA**-mom's sister, **MU**-mom's brother
PGM-dad's mom, **PGF**-dad's dad, **PA**-dad's sister, **PU**-dad's brother

	Family Member – Explain/Condition			Family Member – Explain/Condition
Alcohol/Drug Abuse/Addiction			Growth disorder	
Anemia/Bleeding tendency			Heart disease/disorder/defect	
Asthma/Breathing problems			High Blood Pressure	
Behavioral problems (ex: ADHD, ADD, ODD)			High Cholesterol	
Birth Defects			HIV/AIDS	
Blood disorder (other than anemia)			Kidney/Bladder disease/disorder	
Cancer			Lung disease (other than Asthma)	
Cystic Fibrosis			Migraines	
Dermatologic/Skin issues/disorder			Muscle or Orthopedic Issues – Bone Joint disease	
Developmental disorder (ex: Autism)			Neurologic Issues (other than seizure; ex: Cerebral Palsy)	
Diabetes			Psychiatric issues	
Ear disorders/Hearing Impairment			Rheumatologic issues	
Endocrinology			Seizure or Epilepsy	
Eye disorder/Vision Impairment			Thyroid disorder ☐ hypo- ☐ hyper- ☐ cancer	
Gastrointestinal/Bowel/Stomach disorder/problems			OTHER:	
Genetic disorder (specify)			OTHER:	

If there have been deaths in family members prior to age 50, please list family member relationship, age reason:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my child's health. It is my responsibility to inform the providers office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary healthcare services my child may need.

Parent or Legal Guardian Name (Print): _____ Relationship to Patient: _____

Parent or Legal Guardian Signature: _____ Date: _____