# Bear Creek PEDIATRICS

NEW PATIENT REGISTRATION

## PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City/State/Zip: _____ Email: _____

Gender: ☐ Female ☐ Male Reminder: ☐ Voicemail ☐ Text ☐ Email ☐ None

## GUARDIAN INFORMATION

Mother: _____ Father: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Date of Birth: _____ Date of Birth: _____

Employer: _____ Employer: _____

## ALTERNATE CONTANCT (Permission to Treat)

Name: _____ Name: _____

Phone: _____ Phone: _____

Relation: _____ Relation: _____

## PRIMARY INSURANCE INFORMATION

Insurance: _____ Policy No: _____

Policy Holder: _____ Group No: _____

## SECONDARY INSURANCE INFORMATION

Insurance: _____ Policy No: _____

Policy Holder: _____ Group No: _____

**Bear Creek**
PEDIATRICS

PATIENT HISTORY

## HOUSEHOLD INFORMATION

Patient Name: _____ Date of Birth: _____

Guardianship: ☐ Both Parents ☐ Joint Custody ☐ Single Custody (who?) _____
☐ Grandparents ☐ Adoptive Parents ☐ Other _____

Family Lives In: ☐ Single-Family Hm ☐ Apartment/Duplex ☐ Other _____

Exposures: ☐ Pets/Animals ☐ Wood Smoke ☐ Inside Cigarette Smoke ☐ Outside Cigarette Smoke
☐ Alcohol Abuse ☐ Domestic Violence ☐ Marijuana/Vaping ☐ Guns

| PATIENT LIVES WITH | RELATION TO PATIENT | PATIENT LIVES WITH | RELATION TO PATIENT |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## BIRTH HISTORY

Birth Weight: _____ Wks Gestation: _____ Initial Feeding: ☐ Formula ☐ Breast (how long?) _____

Prenatal Concerns: ☐ No ☐ Yes (explain): _____

Delivery Method: ☐ Vaginal ☐ Cesarean (explain): _____

NICU Stay Required: ☐ No ☐ Yes (explain): _____

During pregnancy did mom use: ☐ Prenatal vitamins ☐ Medication ☐ Alcohol ☐ Tobacco ☐ Drugs

| CURRENT MEDICATIONS (Include vitamins, fluoride, allergy medication, etc.) | CURRENT ALLERGIES (Include food, medication, environs, etc.) | CURRENT MEDICAL CONDITIONS |
|---|---|---|
| | | |
| | | |
| | | |

| PAST SURGURIES | PAST MEDICAL CONDITIONS |
|---|---|
| | |
| | |

## SEES SPECIALISTS

☐ Asthma/Allergy _____
☐ Cardiology _____
☐ Counselor/Psychologist _____
☐ Dentist _____
☐ Dermatology _____
☐ ENT _____
☐ Endocrinology _____
☐ Gastroenterology _____
☐ Neuro/Development _____
☐ Occupational Therapy _____
☐ Physical Therapy _____
☐ Pulmonology _____
☐ Speech Therapy _____
☐ Other _____