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 CONTACT WITH PERMISSION TO TREAT

(Any persons listed below have permission to bring the patient to our office in the guardian's absence.)

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

PLEASE LIST ALL PEOPLE CURRENTLY LIVING IN THE SAME HOUSEHOLD AS THE PATIENT AND THEIR RELATIONSHIP TO THE 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 SURGERIES	PAST MEDICAL CONDITIONS

PLEASE NAME ANY SPECIALISTS THE PATIENT IS CURRENTLY SEEING

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