

JUST KIDZ PEDIATRICS REGISTRATION FORM

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Social Security No.:	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City & State:		ZIP Code:		
Home Phone No.: ()			Cell Phone No.: ()		School Name:	School Address:	
Mother's Name:			Father's name:				
Chose clinic because/Referred to clinic by (<i>please check one box</i>):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:							

INSURANCE INFORMATION							
<i>(Please give your insurance card to the receptionist.)</i>							
Person responsible:		Birth date: / /	Address (if different):			Home phone No.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone No.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				Effective date: / /			
Please indicate primary insurance <input type="checkbox"/> Horizon BCBS <input type="checkbox"/> Aetna <input type="checkbox"/> United Healthcare <input type="checkbox"/> Cigna <input type="checkbox"/> Empire							
<input type="checkbox"/> GHI <input type="checkbox"/> Oxford Health Plans <input type="checkbox"/> QualCare <input type="checkbox"/> Medicaid (<i>Indicate group in next box</i>) <input type="checkbox"/> Other							
Subscriber's name:		Subscriber's S.S. No.:	Birth date: / /	Group No.:	Policy No.:	Co-payment: \$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
Name of secondary insurance (<i>if applicable</i>):			Subscriber's name:		Group No.:	Policy No.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							

IN CASE OF EMERGENCY				
Name of local friend or relative (<i>not living at same address</i>):		Relationship to patient:	Home phone No.: ()	Work phone No.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Just Kidz Pediatrics or insurance company to release any information required to process my claims.				
Patient/Guardian signature			Date	

JUST KIDZ PEDIATRICS PATIENT QUESTIONNAIRE

Today's date:	PCP:
PREGNANCY & BIRTH	DEVELOPMENT & BEHAVIOR
Mother's age at pregnancy?	<i>At what age did child:</i>
Any illness during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sat alone: <input type="checkbox"/> Walked: <input type="checkbox"/> Used phrases: <input type="checkbox"/>
Medications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(exclude iron & vitamins)</i>	Toilet trained: <input type="checkbox"/> Bicycled: <input type="checkbox"/>
Any Smoking – Alcohol – Street Drugs – during pregnancy?	Development compared to other children?
Was baby – early – late – on time?	Grade in school: <input type="checkbox"/> Problems in school? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of delivery? Birth weight: Length:	
Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Apgar Score: <input type="checkbox"/>	Learning problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with baby at birth? Breathing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gets along with other children? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing: <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No	Behavior problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	Bad habits? <input type="checkbox"/> Yes <input type="checkbox"/> No Bed wetting? <input type="checkbox"/> Yes <input type="checkbox"/> No
Problems soon after? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nail biting? <input type="checkbox"/> Yes <input type="checkbox"/> No Sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No
Nursery or home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Use of street or illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No

PAST MEDICAL HX	FAMILY MEDICAL HX						
Allergic reactions? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Please check if it applies.</i>						
Food <input type="checkbox"/> Yes <input type="checkbox"/> No Insect bites: <input type="checkbox"/> Yes <input type="checkbox"/> No	Disease:	M	F	MM	FM	MF	FF
<i>If 'Yes' please explain:</i>	Anemia/Blood disorder						
Medications taken on a regular basis? <i>(exclude vitamins)</i>	Arthritis						
	Asthma						
Immunizations –upto date <input type="checkbox"/> Yes <input type="checkbox"/> No Have record : <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Defects						
Hospitalizations- <i>(when-where-why?)</i>	Cancer						
	Cholesterol problem						
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Problems hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	Cystic Fibrosis						
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Red Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes						
Bleeding problems <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Early Deafness						
Blood transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/ Seizures						
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease						
Ear infections <input type="checkbox"/> Yes <input type="checkbox"/> No Sweating <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure						
Eczema/ Hives <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary infections <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine						
German Measles <input type="checkbox"/> Yes <input type="checkbox"/> No Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy						
Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No Whooping cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia						
Joint Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Other	Tuberculosis						
Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No Other	Other:						