JUST KIDZ PEDIATRICS
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Social Security No.:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ 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 *(please check one box):*	❑ Dr.		❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible:	Birth date: / /	Address (if different):	Home phone No.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone No.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No | Effective date: / /

Please indicate primary insurance ❑ Horizon BCBS ❑ Aetna ❑ United Healthcare ❑ Cigna ❑ Empire

❑ GHI ❑ Oxford Health Plans ❑ QualCare ❑ Medicaid *(Indicate group in next box)* ❑ Other

Subscriber's name:	Subscriber's S.S. No.:	Birth date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance *(if applicable):*	Subscriber's name:	Group No.:	Policy No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (*not living at same address):*	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 QUESTIONNARE

Today's date:	PCP:

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

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