

WESTLAKE PEDIATRICS

Child's Name:

Date Of Birth:

Gender:

_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Lives with: _____

Emergency Contact _____ Phone _____
(Not the parents)

Mother _____ Home Phone _____
Address _____ City _____
State _____ Zip Code _____ Cell Phone _____
Employer _____ Occupation _____
Work Phone _____ SSN _____ DOB _____

Father _____ Home Phone _____
Address _____ City _____
State _____ Zip Code _____ Cell Phone _____
Employer _____ Occupation _____
Work Phone _____ SSN _____ DOB _____

Name of insurance policyholder _____
Phone _____ SSN _____ DOB _____

Individual responsible for payment _____

The physicians of Westlake Pediatrics have my permission to diagnose and treat my child/children in my absence when he/she is accompanied by the following person(s):

I understand that I am responsible for the payment of all services rendered by Westlake Pediatrics, and that such services are to be paid at the time of service unless prior arrangements have been made with the proper staff. Any charges not covered by the insurance remain my responsibility to pay within 30 days of the date notified.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Signature Relationship Date

INITIAL HISTORY AND HEALTH ASSESSMENT

Date _____ Patient Name _____ Male Female DOB _____

Complications with pregnancy, labor and/or delivery?

ALLERGIES/REACTIONS:

Please check to indicate HISTORY of any of the following in the patient's **IMMEDIATE FAMILY**.

	Allergies (specify)	Asthma	Diabetes	Epilepsy Convulsions	Tuberculosis	Other (list)	Other (list)	Other (list)
Mother								
Father								
Sibling								

Please provide the following regarding the PATIENT'S medical history and current health status.

Previous Physician _____ Phone _____

Specialist _____ Phone _____

Illness	Yes	No	Age Of Onset (or date of diagnosis if known)	Is patient currently on any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list)		
				Medication	Dosage	Frequency
Asthma						
Chickenpox						
Measles						
Mumps						
Otitis (Ear infection)						
Respiratory Infection						
Rubella						
Tonsillitis						
Other						

List any serious accidents/injuries/illnesses, hospitalizations and/or operations and the approximate dates.

Description	Date	Description	Date

Please answer the following questions regarding the patient's behavior/social habits.

Is the patient having problems in any of the following? Behavior Interaction with peers School performance

Please describe _____

Is there any indication of past or present use of the following?

If yes, please not frequency

Tobacco Yes No _____

Alcohol Yes No _____

Controlled Substances Yes No _____