West End Pediatrics
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4600 Duke Street, Suite 332
Alexandria, VA 22304
(703) 823-7400

Date ____________

Home Phone ____________

(PLEASE PRINT)

PATIENT INFORMATION

Name of Minor/Child ____________ Last Name ____________ First Name ____________ Initial

Sex ☐ M ☐ F Age ______ Birthdate ____________ Nickname ____________ Hobbies ____________

Home Address ____________ Street ____________ City ____________ State ____________ Zip

Mailing Address ____________ Street ____________ City ____________ State ____________ Zip

Person financially responsible ____________ Home Phone ____________ Work Phone ____________

Whom may we thank for referring you? ____________

PARENT(S) / GUARDIAN

Father's/Guardian's Name ____________

Address (if different from patient's) ____________

____

Home Phone ____________ (if different from above) Work Phone ____________ (if different from above)

Employer ____________

Soc. Sec. # ____________ Birthdate ____________

Do you have insurance coverage for minor? ☐ Yes ☐ No ______

If yes, continue

Plan Name ____________

Phone No. ____________

Address ____________

____

Group # ____________

Policy # ____________

Mother's/Guardian's Name ____________

Address (if different from patient's) ____________

____

Home Phone ____________ (if different from above) Work Phone ____________ (if different from above)

Employer ____________

Soc. Sec. # ____________ Birthdate ____________

Do you have insurance coverage for minor? ☐ Yes ☐ No

If yes, continue

Plan Name ____________

Phone No. ____________

Address ____________

____

Group # ____________

Policy # ____________

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance Identification # ____________

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? (other than parents)

Name ____________ Relationship ____________ Phone ____________

Name ____________ Relationship ____________ Phone ____________

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

____________ Signature of Parent/Guardian ____________ Date

BIRTH HISTORY

Hospital ______ Obstetrician ______

Type of delivery ______ Complications ______

Birth Weight ______ Birth Length ______ Discharge Weight ______

Did baby have any problems at or immediately after birth? ______

List Age ______ Cooed or laughed ______ Sat ______ First Word ______ Held Head Up ______ Walked ______ Toilet Trained ______

HEALTH HISTORY

Minor/Child's Physician ______ City/State ______ Phone ______

Date of last examination ______ Results ______

	YES	NO	
Is Minor/Child under care of physician now? ______	☐	☐	Medications ______
Receiving any medication or drugs? ______	☐	☐	______
Has your child been hospitalized? ______	☐	☐	______

Date Reason Hospital

Allergies ______

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Chicken Pox	☐	☐	Heart Problems	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Constipation, Diarrhea	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Kidney Disease	☐	☐	Speech Problems
☐	☐	Bed Wetting	☐	☐	Diabetes	☐	☐	Lead Poisoning	☐	☐	Thyroid Disease
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Measles	☐	☐	Urinary Disease
☐	☐	Bleeding, excessive	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Cancer	☐	☐	Fainting	☐	☐	Mumps	☐	☐	Worms
☐	☐	Cerebral Palsy	☐	☐	Hearing Problems	☐	☐	Pneumonia	☐	☐	Other

IMMUNIZATIONS

Check (√) whether or not your minor/child has been given the following immunizations. If yes, please fill in the date given.

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
☐	☐	______	DPT Series of 3 shots	☐	☐	______	Polio by mouth, series of 3	☐	☐	______	Diphtheria Tetanus
☐	☐	______	DPT Booster shots	☐	☐	______	Measles Vaccine	☐	☐	______	Tuberculin Test
☐	☐	______	Polio Shots series of 3	☐	☐	______	Mumps Vaccine				Result ______
☐	☐	______	Polio Booster Shots	☐	☐	______	Rubella Vaccine				______

FAMILY HISTORY

Has any member of the family or close relative had:

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Mental Disorders
☐	☐	Asthma or Hay Fever	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Hemophilia – Bleeder	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Other ______
☐	☐	Convulsion or Epilepsy	☐	☐	Kidney Disease			______

(OVER)

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