Mt. Spokane pediatrics

Name_____Date of Birth_____

Gender ☐ M ☐ F Age___SSN#_____Email_____

Home Address_____City_____State_____ZIP_____

Phone Number _____Phone Number_____

Your Child's Race/Ethnicity ☐ American Indian or Alaskan Native ☐ Asian

☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Multiracial

☐ Unknown ☐ Other ☐ Decline to Answer

Household / Parent / Guardian Information / Insurance Information

Please list all those living in your child's home

Name	Birth Date	Relationship	Notes

Please list any other names _____

_____

_____

How did you hear about us _____

_____

Who was your Child's previous medical provider_____

_____

Parent Name_____Date of Birth_____

Cell Phone Number_____Work Phone Number_____

Home address*(if different from child)* _____

City_____State_____ZIP_____

SSN_____Employer_____

Occupation_____

Parent Name_____Date of Birth_____

Cell Phone Number_____Work Phone Number_____

Home address(if different from child)_____

City_____State_____ZIP_____

SSN_____Employer_____

Occupation_____

Alternate Contact Name_____

Alternate Contact Phone_____Relationship_____

9425 N. Nevada, Ste. 104, Spokane, WA 99218 • 509-270-0065 *office* 509-319-2520 *fax* • info@mtspokanepediatrics.com

Insurance/Responsible Party Information ☐ parent ☐ guardian ☐ self

Name_____Date of Birth_____

Address*(if different from child)*_____

SSN_____Cell Phone Number_____

Primary Insurance Name_____

Address_____

Phone Number_____ID Number_____

Group Number_____Employer_____

Employer Phone Number_____

Secondary Insurance Name_____

Address_____

Phone Number_____ID Number_____

Group Number_____Employer_____

Employer Phone Number_____

Primary Doctor / Family Doctor_____

Birth History ☐ Don't know birth history

Birth weight_____Was the baby born at term?_____or_____weeks_____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?_____

_____

Were there any prenatal or neonatal complications? ☐ Yes ☐ No Explain_____

_____

Was a NICU stay required? ☐ Yes ☐ No Explain_____

_____

Was initial feeding ☐ Formula ☐ Breast Milk How long breastfed?_____

Did you baby go home with mother from the hospital? ☐ Yes ☐ No Explain_____

_____

During Pregnancy, did mother Use Tobacco ☐ Yes ☐ No

Use Medications ☐ Yes ☐ No Drugs or Alcohol Use ☐ Yes ☐ No

What_____When_____

☐ Used Prenatal Vitamins

Allergies

☐ No Known Allergies ☐ Sulfa Drugs ☐ Codeine

☐ Penicillin ☐ Adhesive Tape ☐ Anesthesia

☐ Latex ☐ Iodine/Shellfish/Contast Dye ☐ Food/Other

Please Describe:_____

_____

_____

_____

Family History - Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box

	Mother	Father	Siblings
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

Other Please Describe:_____

_____

_____

Surgical History - Please list any hospitalzations,surgeries,fractures,major illnesses

Type of Surgery	Date	Doctor and or Office

Past Medical History - Have you ever had any of the following:

- ☐ No Known Medical Issues
- ☐ ADHD
- ☐ Anemia
- ☐ Arthritis Conditions
- ☐ Asthma
- ☐ Autism
- ☐ Bipolar
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ GERD (reflux)
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Infection Problems
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Problems
- ☐ Migraines/Headaches
- ☐ Onychomycosis
- ☐ Organ Injury
- ☐ Osteoporosis
- ☐ Pulmonary Embolism/Blood Clot in Legs
- ☐ Seizure Disorders
- ☐ Shortness of Breath
- ☐ Sinus Conditions
- ☐ Stroke
- ☐ Tremors

Please list any details or other conditions below:_____

_____

_____

_____

_____

Medication History

Medication	Dosage	Prescribing Doctor

ASSIGNMENT AND RELEASE :

I herby authorize my insurance benefits be paid directly to Mt Spokane Pediatrics and I am financially responsible for non-covered services. I also authorize Mt Spokane Pediatrics to release any information required in the process of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Printed Name (Parent or Guardian) Date

_____ _____

Signature (Parent or guardian) Date

_____ _____