MT. SPOKANE pediatrics

North Office
759 E Holland # 101
Spokane, WA 99218

Valley Office
1301 N Pines Rd #100
Spokane Valley, WA 99206

Patient Information

Patient Name _____ Date of Birth _____

Gender M F Age _____ Primary Phone Number _____ Email _____

Mailing Address _____ City _____ State _____ Zip _____

Emergency Contact Name & Number _____

Who was the previous medical provider for your child/children? _____

How did you hear about us? _____

Other family members seen at our office(s) _____

_____

Child's Race/Ethnicity

- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Multiracial
- ☐ Hispanic or Latino
- ☐ Hawaiian Native or Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Decline to Specify
- ☐ Unknown

Insurance Info

Primary Insurance Name _____ Secondary Insurance Name _____

ID Number _____ ID Number _____

Group Number _____ Group Number _____

If your child has more than two insurances, please list them here _____

Parent/Guardian Information

Name _____ Date of Birth _____ SSN _____

Cell Phone Number _____ Work Phone Number _____

Mailing Address ☐ Same as patient or _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Relationship to patient ☐ Mother ☐ Father ☐ Legal Guardian ☐ Stepparent

Is this parent/legal guardian the Guarantor/Responsible Party for your child's insurance? Yes ☐ No ☐

Name _____ Date of Birth _____ SSN _____

Cell Phone Number _____ Work Phone Number _____

Mailing Address ☐ Same as patient or _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Relationship to patient ☐ Mother ☐ Father ☐ Legal Guardian ☐ Stepparent

Is this parent/legal guardian the Guarantor/Responsible Party for your child's insurance? Yes ☐ No ☐

Surgical History

Please list any hospitalizations, surgeries, fractures, or major illnesses

Type of Surgery/Injury	Date	Doctor and/or Office

Family History

Please indicate if any of your child's immediate relatives have had any of the following by placing an X in the appropriate box

	Mother	Father	Siblings
Anesthesia Problems			
Asthma/Allergies			
Cancer			
Diabetes			
Cardiovascular Disease			
Autoimmune Disorder			
GI Disorder			
Thyroid/Endocrine Disorder			

Other history - please describe: _____

Medication History

Medication	Dosage	Prescribing Medical Provider

Past Medical History

Has your child ever had one of the following:

- ☐ ADHD
- ☐ Anemia
- ☐ Arthritis Conditions
- ☐ Asthma
- ☐ Autism
- ☐ Birth Complications
- ☐ Bipolar
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ GERD (reflux)
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Infection Problems
- ☐ Intrauterine Drug Ex
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Problems
- ☐ Migraines or Headaches
- ☐ Premature Delivery
- ☐ Seizure Disorders
- ☐ Shortness of Breath
- ☐ Sinus Conditions
- ☐ Stroke
- ☐ Tremors
- ☐ Other
- ☐ No Known Medical Issues

Please list any details or other conditions below:

_____

_____

_____

Allergies

- ☐ Adhesive Tape
- ☐ Anesthesia
- ☐ Codeine
- ☐ Food/Other
- ☐ Iodine/Shellfish/Contrast Dye
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ No Known Allergies

Please Describe: _____

_____

_____

Assignment and Release

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

_____

Printed Name (Parent/Legal Guardian)

_____ _____

Signature (Parent/Legal Guardian) Date