

PEDIATRIC PATIENT INTRODUCTION

Child's Name: _____ Mother's Name: _____
Father's Name: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Home Phone: _____ Mother's Work: _____ Father's Work: _____
Birth Date: ____-____-____ Age: _____ Birth Weight: _____ Current Weight: _____

Sex: _____ No. of Siblings: _____ Birth Length: _____ Current Length: _____

Type of Birth: Normal Vaginal _____ Forceps _____ Breech _____ Cesarean _____
Home: _____ Birthing Center: _____ Hospital: _____

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Apgar Scores: ____ ____ Was There Presence at Birth Of: _____ Jaundice (yellow) Cyanosis (Blue)
Congenital Anomalies/Defects: _____

Infant Feeding: Breast _____ Bottle _____ Formula _____

No. of Hours Sleep Per Night: _____ Quality of Sleep: Good ____ Fair ____ Poor ____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Date of Last Visit to MD: _____

Immunization History: _____

Purpose of this Appointment: _____

Has Your Child Been Treated on an Emergency Basis?: _____

Describe: _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this clinic and it's Doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: ____-____-____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-Rays remain the property of this clinic

Date: ____-____-____ Signature: _____

