PEDIATRIC PATIENT INTRODUCTION

Child's Name: ___________________________ Mother's Name: _________________________________
Father's Name: _________________________________

Address: ___________________________ City/Town: __________ Sate: ________ 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: ____