

SOUTHSIDE PEDIATRICS, INC.

PATIENT INFORMATION

DATE _____ SSP ACT.# _____

(PLEASE PRINT ALL INFORMATION)

PATIENT NAME _____ DATE OF BIRTH _____
Last First M.

ADDRESS _____
Street - Apt. # - Lot #

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # () _____ PATIENT SEX M ___ F ___ AGE _____ SS# _____

MOTHER'S NAME _____ DOB _____ SS# _____

ADDRESS _____ HOME PHONE # () _____

EMPLOYER _____ BUSINESS PHONE # () _____
Name Address

CELL PHONE # () _____

FATHER'S NAME _____ DOB _____ SS# _____

ADDRESS _____ HOME PHONE # () _____

EMPLOYER _____ BUSINESS PHONE # () _____
Name Address

CELL PHONE # () _____

OTHER RELATIVE OR FRIEND IN CASE OF EMERGENCY _____

ADDRESS _____ TELE # () _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____
Name Address

IDENTIFICATION # _____ GROUP # _____

SECONDARY INSURANCE CARRIER _____
Name Address

IDENTIFICATION # _____ GROUP # _____

OTHER CHILDREN IN FAMILY: Last Name First Name MI

REFERRED BY: _____

MEDICAL HISTORY

Please check if child has ever had any of the following:

- Allergies to Medicine

- Allergies- Environmental

- Anemia
- Asthma
- Bronchitis
- Chicken Pox
- Hepatitis
- Measles (10-day)
- Measles, Rubella (3-day)
- Mumps
- Rheumatic Fever
- Pneumonia
- Whooping Cough

GENERAL

- Dizziness
- Epilepsy
- Fainting
- Headache
- Numbness
- Sweating
- Tiredness
- Weight Loss/Gain

FAMILY HISTORY OF:

- Allergies
- Asthma
- Diabetes
- Epilepsy
- High Blood Pressure
- Smokers in the Home

CARDIOVASCULAR

- Breathing Problems
- Chest Pain
- High Blood Pressure
- Irregular Heart Beat

EYES

- Crossed or Wandering Eyes
- Eye Irritation
- Headaches
- Vision Problems

HEARING/SPEECH

- Difficulty Hearing
- Earache
- Ear Infections
- Hoarseness
- Speech Problems _____

DENTAL

- Bleeding Gums
- Sensitivity to Hot/Cold
- Thumb-Sucking
- Last Dental Check-Up
Date _____

GASTROINTESTINAL

- Appetite Poor
- Bloody or Dark Stools
- Constipation
- Diarrhea
- Excessive Thirst
- Nausea
- Rectal Bleeding
- Stomachaches
- Vomiting
- Worms

GENITO-URINARY

- Bed-Wetting
- Blood in Urine
- Diaper Rash, Persistent
- Frequent Urination
- Painful Urination

MUSCLE/JOINT/BONE

- Broken Bones or Sprains
- Coordination Problems
- Posture Problems

Pain, Weakness, Swelling in:

- Arms
- Hands
- Feet
- Legs

NOSE/THROAT/CHEST

- Frequent Colds
- Hoarseness
- Mouth-Breathing
- Nosebleeds
- Persistent Cough
- Sinus Problems
- Sore Throats
- Strep Throat
- Wheezing

SKIN

- Bruise Easily
- Change in Moles
- Hives
- Itching
- Rash
- Sores that wont Heal

ANY OTHER PERTINENT FAMILY MEDICAL HISTORY: _____

Patient's Authorization to Release Medical Information & Claim Payment

I hereby authorize the above physician(s) to release any information regarding services rendered by him/her and allow a photocopy off my signature to be used to file my insurance.

(Date)

Patient (Parent/Guardian) Signature

I hereby authorize and direct my insurer to issue payment check(s) for benefits due to me for the services rendered by the above named physician(s) to be made directly to him. Regardless of my insurance benefits, if any. I understand I am financially responsible for the fees for services rendered unto me.

(Date)

Patient (Parent/Guardian) Signature