FIFTH AVENUE PEDIATRICS, P.A.
CONFIDENTIAL PATIENT INFORMATION

Today's date_____________

Parent #1 (Mother/Father) Please circle.

Full name_______________________________________ Date of birth ___________________

Address ____________________________ City ___________________ State ______ Zip _________

Home phone __________________Cell phone ____________________Work ___________________

Occupation ________________________________ Employer ________________________________

Email Address ____

Parent #2 (Mother/Father) Please circle.

Full name_______________________________________ Date of birth ___________________

Address ____________________________ City ___________________ State ______ Zip _________

Home phone __________________Cell phone ____________________Work ___________________

Occupation ________________________________ Employer ________________________________

Email Address ____

Children and Newborns **DOB** **Gender**

1.____

2.____

3.____

In case of emergency, notify: ___________________________ Phone_________________________

Insurance: Name of insured____ DOB___________

Name of insurance company____

Claims Address ________________________ City___________________ State______ Zip ________

Member ID #_______________________________ Group #________________________

Referred to us by? ____

Confidential Patient Information

Family History: Has anyone in your family had the following problems? (Please check yes or no)

	Yes	No		Yes	No
Heart Disease	_______	_______	Abdominal Problems	_______	_______
High Cholesterol	_______	_______	Migraines	_______	_______
Diabetes	_______	_______	Eye/Vision Problems	_______	_______
Allergies/Hay Fever	_______	_______	Hearing Problems	_______	_______
Lung Disease	_______	_______	Immune Disorders/HIV	_______	_______
Kidney Disease	_______	_______	Blood Disorders	_______	_______
Liver Disease	_______	_______	Sickle Cell	_______	_______
Thyroid Disease	_______	_______	Psychiatric Illness		
Cystic Fibrosis	_______	_______	Including Drug or		
Cancer	_______	_______	Alcohol Dependence	_______	_______

Social History:

Who lives at home with patient? ____

Any pets? If so, what kind? ____

Any smokers? ____

Do you live in an area with fluoridated water? ____

Any alcohol consumption at home? ____________ Average intake___________________________________

Previous Medical Problems:

____

____

____

Has your child had chicken pox? ____

Has your child been exposed to tuberculosis? ____

Has your child been exposed to Hepatitis? ____

Previous Surgery:

Procedure **Date**

____

____

Previous Hospitalizations (other than surgery):

Problem **Date**

____

____

Allergies: ____

Current Medications (including over the counter): ____

____

Are your child's immunizations up to date? ____