SIBLINGS

NAME	BIRTH DATE
______	______
______	______
______	______
______	______

CHILDREN'S MEDICAL GROUP
of Orange County

Date ______

Home Phone ______

PATIENT INFORMATION

Name of Minor/Child ______ Last Name ______ First Name ______ Initial

Sex ☐ M ☐ F Age______ Birthdate ______ Nickname ______ Hobbies ______

Home Address ______ Street ______ City ______ State ______ Zip

Mailing Address______ Street ______ City ______ State ______ Zip

Person financially responsible______ Home Phone______ Work Phone______

Whom may we thank for referring you? ______

Father's / Guardian's Name ______

Address (if different from patient's) ______

______

Home Phone______ (If different from above) Work Phone______ (If different from above)

Employer ______

Soc. Sec.#______ Birthdate ______

Are you the subscriber? ☐ Yes ☐ No

Plan Name ______

Phone No. ______

Address ______

______

Group ______

Policy# ______

Mother's / Guardian's Name______

Address (if different from patient's) ______

______

Home Phone______ (If different from above) Work Phone______ (If different from above)

Employer ______

Soc. Sec.#______ Birthdate ______

Are you the subscriber? ☐ Yes ☐ No

Plan Name ______

Phone No. ______

Address ______

______

Group ______

Policy# ______

EMERGENCY CONTACT

In the event of an emergency, other than parent, whom should we contact

Name______ Relationship ______ Phone______

Name______ Relationship ______ Phone______

FAMILY HISTORY

Has any member of the family or close relative had:

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Mental Disorders
☐	☐	Asthma or Hay Fever	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Hemophilia - Bleeder	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Elevated Cholesterol______
☐	☐	Convulsion or Epilepsy	☐	☐	Kidney Disease	☐	☐	Other______

(OVER)

BIRTH HISTORY

Hospital________________________________ Obstetrician ________________________

Type of delivery________________________ Complications ________________________

Birth Weight______________ Birth Length______________ Discharge Weight ______________

Did baby have any problems at or immediately after birth? ________________________

List Age Cooed or laughed________ Sat________ First Word________ Held Head Up________ Walked________ Toilet Trained ________

HEALTH HISTORY

Minor/Child's Physician______________________ City/State______________ Phone______________

Date of last physical examination______________ Results ______________________

	YES	NO	
Is Minor/Child under care of physician now? ______	☐	☐	Medications ______________________
Receiving any medication or drugs? ______	☐	☐	______________________
Has your child been hospitalized? ______	☐	☐	______________________

Date Reason Hospital

______________________________ Allergies ______________________

______________________________ ______________________

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Chicken Pox	☐	☐	Heart Problems	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Constipation, Diarrhea	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Kidney Disease	☐	☐	Speech Problems
☐	☐	Bed Wetting	☐	☐	Diabetes	☐	☐	Lead Poisoning	☐	☐	Thyroid Disease
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Measles	☐	☐	Urinary Diseases
☐	☐	Bleeding, excessive	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Cancer	☐	☐	Fainting	☐	☐	Mumps	☐	☐	Worms
☐	☐	Cerebral Palsy	☐	☐	Hearing Problems	☐	☐	Pneumonia	☐	☐	Other

If your child(ren) need(s) medical treatment and come in or is brought in by any other person other than parents or legal guardian, please sign if you consent to your child(ren) being treated in your absence.

I/We consent: ____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with ________________________________
Name of Insurance Company(ies)

and assign directly to Dr.______________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

____
Signature of Parent/Guardian Date