



Caring Pediatrics
4439 Rowan Rd.

New Port Richey, FL 34653
Phone (727)853-2273 Fax (727) 853-2277
www.caringpediatrics.com

Caring Pediatrics – Patient Profile

PATIENT INFORMATION

Today's Date: _____

Name: _____

Sex: • Male • Female

Address: _____

Date of Birth ____/____/____

Social Security #: ____-____-____

Parent/Guardian 1: _____ Relationship: _____ SS# _____

Parent/Guardian 2: _____ Relationship: _____ SS# _____

- Adopted • Foster Care

Phone: (____) _____ • H • C • W • Other _____

(____) _____ • H • C • W • Other _____

(____) _____ • H • C • W • Other _____

Email (optional): _____

INSURANCE INFORMATION

Primary Insurance:

- I do not have Health Insurance – *Please fill out who is responsible for payment in the section below.*

Information is: • Same as Patient

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Address: _____

Subscriber's Date of Birth: ____/____/____

Subscriber's Social Security #: ____-____-____

Subscriber's Phone: (____) _____

Policy Number: _____

Name of Insurance: _____

Group Number: _____

Employer: _____

Secondary Insurance:

Information is: • Same as Patient

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Address: _____

Subscriber's Date of Birth: ____/____/____

Subscriber's Social Security #: ____-____-____

Subscriber's Phone: (____) _____

Policy Number: _____

Name of Insurance: _____

Group Number: _____

Employer: _____



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Patient Name: _____

Date of Birth: _____

PREGNANCY AND DELIVERY INFORMATION

How many pregnancies has the patient's mother had? _____ Live Births _____ Stillborn _____ Miscarriages _____

Please list any complications or infections during the pregnancy or at the time of delivery:

Smoking: _____ cigarettes/day Alcoholic drinks: _____ per week Drugs/Medicine _____

Where was the patient born? _____

• Cesarean • Natural • Forceps/Vacuum

Medications to mother during labor: _____

Group B Strep: positive negative

Birth weight: _____ Length: _____ APGARs ____/____

Days in hospital: _____

Born at _____ weeks Hearing: Passed Failed- R/L

Newborn issues: • Jaundice • Feeding Problems • Vomiting • Blueness • Needed oxygen • Fever • Seizures
• Breathing Problems • Blood Transfusion • Other: _____

PATIENT'S PAST MEDICAL HISTORY

Previous Physician's/Clinic Name: _____ City, State _____

Date of Last Physical: _____

Has the patient ever been hospitalized? _____ If yes, for what and when?

Previous surgeries: _____

Has your child ever been or currently being treated for the following illnesses?

- ADHD • Hepatitis • Measles • Whooping Cough (Pertussis) • Chicken Pox (date)_____ • Broken Bones
- Ear Infections • Pneumonia • Head Injury • Urine Infection • Allergies • Skin Problems • Headaches • Asthma
- Lead Poisoning • Behavior Problems • Learning Problems • Developmental Problems • Vision Problems
- Acid Reflux • Seizures • Heart Murmur • Depression/ Anxiety • Diabetes • Speech Problems • Cancer
- Hearing Problems • Others conditions not listed _____

Medications (including Over-the-Counter, Natural (Herbal), Etc.): _____

Medication Allergies: _____ Type of Reaction: _____

Food Allergies: _____

Are you followed by any specialists? (if yes, please list) _____

SOCIAL HISTORY

Mother: Age: _____ Occupation: _____

Father: Age: _____ Occupation: _____

Who lives in the home (Relation and Age)? _____

Pets: _____

Does anyone smoke? _____

Primary Language: _____

Daycare: Y/N Religious Preference _____



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Patient Name: _____

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FAMILY HISTORY (Please indicate the relationship to the child)

Diabetes _____	Kidney/Urinary Disease _____
Cancer _____	Mental Illness _____
Seizures _____	Developmental Delay _____
Allergies _____	Heart Disease/Stroke _____
Asthma _____	High Blood Pressure _____
Lung Disease _____	Lead Poisoning _____
Learning Problems _____	Sickle Cell Disease _____
Behavior Problems _____	Immune/Autoimmune Disease _____
Other _____	

SAFETY INFORMATION

Seat Belt/Car Seat used? Yes/No _____	Cigarette Smoking? Yes/No _____
Firearms at home? Yes/No Locked up? Yes/No _____	Domestic Violence? Yes/No _____
Working Smoke Detectors? Yes/No _____	Helmet? Yes/No _____
Where are the medicines kept? _____	Cleaning solutions kept? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Phone: (____) _____

May we leave test results on your home voicemail or answering machine/fax? • Yes • No
May we leave test results on your cell phone voicemail? • Yes • No
Any restrictions to where we may leave results? _____
Pharmacy Preference: _____ Phone: _____ Address _____

How did you hear about Caring Pediatrics? _____

Do you have any concerns or questions for the doctor today? _____

By signing below, I hereby certify that the information furnished on this form is complete, true and accurate, to the best of my knowledge.

Signature: _____ Relationship: _____

Reviewed by: _____ Date: _____