7645 Cita Lane, Ste 102
New Port Richey, FL 34653-6220
Phone: (727)-853-2273 Fax: (727)-853-227
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 _____ Belongs to whom? _____

(____)_____ □H □C □W □Other _____ Belongs to whom? _____

(____)_____ □H □C □W □Other _____ Belongs to whom? _____

Email (required):_____ Spouse's Email: _____

Financial Guarantor or Responsible Party: *(if adding someone other than you, that person **MUST** be present at the first visit and initial this portion in front of the staff.)**MUST BE COMPLETED IN FULL.***

Name: _____ Social Security #: _____-____-_____

Address: _____ Date of Birth _____/_____/_____

_____ Phone: (_____) _____

_____

INSURANCE INFORMATION

Primary Insurance: (Please note under NO circumstances does Caring Pediatric bill secondary claims).

□ I do not have Health Insurance

Information is: □ Same as Patient □ Same as Guarantor

Subscriber's Name: _____ Relationship to Patient:_____

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

Employer: _____ Spouse's Employer: _____

Employer's phone number: _____ Spouse's Employer's phone number: _____

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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: _____

Have you ever been or are 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 □ Other _____

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 _____

Race (circle one)

American Indian Asian Native Hawaiian
Alaskan Native African American White

Ethnicity (circle one)

Hispanic or Latino Not Hispanic or Latino

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Patient Name: _____ **Date of Birth**: _____

FAMILY HISTORY (Please indicate the relationship to the child)

Diabetes _____
Cancer _____
Seizures _____
Allergies _____
Asthma _____
Lung Disease _____
Learning Problems _____
Behavior Problems _____
Other _____

Kidney/Urinary Disease _____
Mental Illness _____
Developmental Delay _____
Heart Disease/Stroke _____
High Blood Pressure _____
Lead Poisoning _____
Sickle Cell Disease _____
Immune/Autoimmune Disease _____

SAFETY INFORMATION

Seat Belt/Car Seat used? Yes/No
Firearms in the home? Yes/No Locked up? Yes/No
Working Smoke Detectors? Yes/No
Where are the medicines kept? _____

Cigarette Smoking? Yes/No
Domestic Violence? Yes/No
Helmet? Yes/No
Cleaning solutions kept? _____

EMERGENCY CONTACT INFORMATION (NOT A PARENT)

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? _____

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: _____