Sunflower Pediatric Clinic

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth (DOB)	Sex	Preferred Name
Sibling's Names:			
Child's Street Address (City, State, Zip Code)	Telephone# where child lives	Parent's Work # Parent #1 _____ Parent #2 _____	Parent's Email Address: Parent #1 _____ Parent #2 _____

Race: ☐White, Non-Hispanic ☐Black, Non-Hispanic ☐ Hispanic ☐Native Hawaiian and other Pacific Islander ☐American Indian or Alaska Native ☐ Asian

If there is insurance for child/children, please present the insurance card to the check-in staff.

Contacts

Parent #1's Name (Last, First, Middle)	Home #	Phone #	Relationship to Patient
Home Address (City, State, Zip Code) (if different from above)			
Parent #2's Name (Last, First, Middle)	Home #	Phone #	Relationship to Patient
Home Address (City, State, Zip Code) (if different from above)			
Emergency Contact (Last, First, Middle)	Home #	Phone #	Relationship
Home Address (City, State, Zip Code) (if different from above)			

Please list the person(s) that you authorize to accompany and give consent for treatment to the child at appointment time, other than a parent or step-parent. If at any time you wish to terminate this authorization you must notify our office in writing of necessary changes.

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

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Who may we thank for referring you to our practice?	Birth Hospital

Guarantor Information (Person financially responsible)

Name	Relationship to Patient		Emancipated Minor? Yes No
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)

Insurance Name	Claims Address	Telephone #
Subscriber ID #	Group #	Patient Relationship to Subscriber:
Subscriber's Name		DOB:
Subscriber Address (if different than guarantor)		Subscriber Employer

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PatientName:_____
DOB:_____
Date:_____

Allergies: (Include name of medication or food, reaction, and age of onset)
_____
_____

Current Problems:
_____
_____

History:

Birth History:

Birth Length: _____ Birth Weight:_____ Birth Head Circumference:_____
Discharge Weight: _____ Gestational Age at Birth (weeks):_____ Delivery Method: Vaginal C-section

If C-section, why? _____

Infant Feeding: Breast Bottle Both
Formula name: _____

Hearing Screening: Pass Fail Re-testing Heart disease screening: Pass Fail

Medical History: (Check any that have been diagnosed and comment below)

_____Hospitalizations?	_____Prematurity	_____Diabetes
_____Asthma	_____GE Reflux	_____Vision problems
_____Allergic Rhinitis	_____Constipation	_____Developmental Delay
_____Eczema	_____Anemia	_____Seizures
_____Wheezing	_____Recurrent Ear infections	_____ADD/ADHD
_____Food Allergies	_____Recurrent Strep	_____Mental Illness
_____Murmur	_____Urinary Tract Infection (UTI)	_____Substance Abuse
_____Congenital Heart Disease	_____Vesicoureteral Reflux (VUR)	

Other Medical History: _____
_____

Surgical History: _____No Surgeries
(Check any past surgeries and complete age/date and surgeon if known)

Procedure	Date or Age	Surgeon
Adenoidectomy		
Appendectomy		
Ear Tubes		
Fundoplication		
Gastrostomy Tube Placement		
Heart Surgery		
Hernia Repair		
Orthopedic Surgery		
Tonsillectomy		
Urological Surgery		
VP Shunt		

Other Surgical History: _____
_____

PatientName:_____
DOB:_____
Date:_____

Family History: (Check any known problems in the family – please complete *at least* for parents and siblings)

Relationship to CHILD		Name	Alive?	No Known Problems		ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mentalillness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		Y N																				
	Father		Y N																				
Siblings	Bro Sis		Y N																				
	Bro Sis		Y N																				
	Bro Sis		Y N																				
	Bro Sis		Y N																				
	Bro Sis		Y N																				
Grandparents	MGM		Y N																				
	MGF		Y N																				
	PGM		Y N																				
	PGF		Y N																				

Comments (including *Other* responses): _____
_____

Relationships: P=Paternal (father's side of family), M=Maternal (mother's side of family), GM=Grandmother, GF=Grandfather
For example: MGM = Maternal Grandmother

Additional Family History (if needed)

Relationship to CHILD	Name	Alive?	No Known Problems		ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mentalillness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
		Y N																				
		Y N																				
		Y N																				
		Y N																				
		Y N																				
		Y N																				

Home Environment:
Number of People at Home: _____
Lives with biological parents: Yes No
Foster Care: Yes No
Primary Care Givers (circle): Parents Daycare Relatives Others:_____
Daycare (hours/day): _____
Time at Relatives (hours/day): _____
Pets: Yes No

Parent's Status: Married Divorced Single Other_____

Parent #1's Occupation _____ **Parent #2's Occupation**_____