PEDIATRIC PATIENT INFORMATION

Child's full name_____ Date of birth_____ Mother's name_____Father's name_____
Address_____City____Zip_____
Phone_____Cell phone_____ Parent email address_____

Birth weight_____Current weight_____Sex_____ No. of siblings_____ Type of birth: Normal vaginal____Forceps___Breech____C-Section_____ Home___Birthing Center___Hospital_____

Problems during pregnancy_____ Problems during labor/delivery_____ Apgar scores_____Was there present at birth: ____jaundice (yellow) _____cyanosis (blue) Congenital abnormalities/defects_____ Infant Feeding: Breast_____Bottle_____Formula_____ No. of hours sleep per night_____Quality of sleep: good__fair__poor___ Name & location of Obstetrician/Midwife_____ Name & location of Pediatrician/Family MD_____ Date of last visit to MD_____Purpose_____ Immunization history_____ Purpose of this appointment_____ Has your child ever been treated on an emergency basis?_____
Describe_____

AUTHORIZATION FOR CARE OF MINOR I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD UPON APPROVAL OF PARENT.

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.

SIGNED_____WITNESSED_____DATE_____