

**READING PEDIATRICS
NEW PATIENT ENROLLMENT FORM**

Please circle one: Child resides with 1) Both Parents 2) Father 3) Mother 4) Other

List full name and date of birth of all children:

1. _____
LAST FIRST DOB

2. _____
LAST FIRST DOB

3. _____
LAST FIRST DOB

4. _____
LAST FIRST DOB

ADDRESS: _____
Street City State/Zip

HOME PHONE: () _____

CELL PHONE: () _____

FATHER'S NAME/DOB _____

MOTHER'S NAME/DOB _____

PREFERRED LANGUAGE: English _____ Spanish _____ Other _____
ETHNICITY: (Please check one) Hispanic or Latino _____ Not Hispanic or Latino _____
RACE: (Please check All that apply) American Indian or Alaska Native _____ Asian _____
Black or African American _____ White _____ Native Hawaiian or Pacific Islander _____

Does this apply for All children? YES or NO If no, please specify _____

EMAIL: _____ CONFIRM EMAIL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____
NAME OF POLICY HOLDER _____
EMPLOYER _____

DOB _____
EFFECTIVE DATE _____

SECONDARY INSURANCE _____
NAME OF POLICY HOLDER _____
EMPLOYER _____

DOB _____
EFFECTIVE DATE _____

If billing address is different than patient, please complete below:

NAME _____
ADDRESS _____

RELATIONSHIP _____

STREET CITY STATE/ZIP

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize READING PEDIATRICS, INC. to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to READING PEDIATRICS, INC.

DATE _____
DATE _____

SIGNATURE _____
RECEPTIONIST RECEIVING ENROLLMENT _____

READING PEDIATRICS
PEDIATRIC PATIENT INFORMATION
COMPLETE ONE PER CHILD

Patient Name: _____

Date of Birth: _____

Name of Parent(s): _____

Home Phone: _____

Address: _____

City/State/Zip: _____

Parent Employer: _____

Work Phone: _____

<p>Patient's Sex: () Male () Female</p> <p>Pregnancy and Birth: Mother's age at Birth: _____ Father's age at Birth: _____ Baby's birth weight: _____ Was baby on time? () Yes () No Type of delivery: () Vaginal () Cesarean Number of days baby stayed in hospital after birth: _____</p> <p>Check if mother had any of the following during pregnancy: () Injections () Bleeding () Rashes () Fever () High Blood Pressure</p>	<p>Previous Primary Care MD:</p> <p>Patient History: Any hospitalizations or surgeries? () Yes () No If yes, date, name of hospital and reason: _____ _____</p> <p>Any serious injuries? () Yes () No If yes, date and injury: _____ _____</p>																					
<p>Nutrition: How is your child's appetite? () Good () Fair () Poor</p> <p>How is/was your infant fed? _____ To what age? () Breast () Bottle _____ Months _____ Yrs.</p> <p>Which of the following foods are included in child's Daily diet? () Skim Milk () 2% Milk () Vegetables () Whole Milk () Meats () Juices () Fruits () Vitamins</p>	<p>Family History: Marital Status: M / S / D Mother's age: _____ Health: () Excellent () Good () Poor</p> <p>Father's age: _____ Health: () Excellent () Good () Poor</p> <p>Number of child's siblings: _____ Step siblings () Yes () No If yes, how many _____ Any serious medical problems? () Yes () No If yes, explain: _____ _____</p>																					
<p>Allergies: Is your child allergic to any foods, medicines, chemicals, plants, other? () Yes () No</p> <p>If yes, give name: _____</p> <p>Reaction: _____ _____</p>	<p>Family Illnesses: Check if a family member has had any of the following</p> <p>() Allergies () Anemia () Epilepsy (seizures) () Diabetes () Asthma () Stroke () Cancer () Sickle Cell () Heart Disease () Mental Disease () High Blood Pressure</p> <p>Other, (please specify): _____ _____</p>																					
<p>Lead Exposure:</p>																						
<p>Do you live in a house built over 30 years ago?</p> <p>Have you done any home remodeling or paint stripping?</p> <p>Do you use imported lead-glazed pottery or ceramic ware?</p> <p>Do you live near a battery plant or an industrial plant that burns solid waste products?</p> <p>Do you or your spouse work in an environment where lead-based substances are used or stored (i.e.) plumber, auto mechanic, printer, lead melter, steel welder, construction worker, gas station attendant, battery manufacturing, bridge construction?</p> <p>Does your child play near roads, freeways or in a place where she/he would breathe auto exhaust fumes or come in contact with contaminated dirt?</p> <p>Does your child eat any nonedible substances such as dirt, wood, clay, plaster, or paint chips?</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">YES</th> <th style="width: 33%;">NO</th> <th style="width: 33%;">DON'T KNOW</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>	YES	NO	DON'T KNOW	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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Please complete other side

Review of Systems:

Check if your child has had the following: () Strep Throat () Asthma () Pneumonia () Seizures
() *Eye Problems/Vision () Frequent Colds () Heart Murmur () Frequent Ear Infections
() Diabetes () Eczema/Skin Rash () Trauma () *Hearing Problem

Please list any other medical problems: _____

Please list any medications that your child takes on a regular basis: _____

List any physicians (other than primary care) you have seen:

Development and Behavior:

At what age did your child sit alone? _____

At what age did your child walk alone? _____

Did he/she say two words by the time he/she was 24 months old? () Yes () No

Did he/she pedal a tricycle/big wheel by age 3 years? () Yes () No

Did he/she count to ten and name two colors by age 4 years? () Yes () No

Did he/she skip and do broad jumps by age 5 years? () Yes () No

Trouble sleeping? () Yes () No

Grade in School: _____

Trouble in School/Learning Disability? () Yes () No

Is patient sexually active? () Yes () No

Check if your child has had any of the following:

() Nail Biting () Nightmares () Bad Temper () Hyperactivity () Problems with Discipline

() Problems with Toilet Training () Substance Abuse () Cigarette Smoking () Alcohol Use

() Speech Problem () Bed Wetting () Thumb Sucking () Bottle after 18 months () Pacifier after 2 years

Safety/Environment:

Is there a working smoke alarm on each floor of the child's home/apartment? () Yes () No

Does your child always use a car seat/seat belt when riding in the car? () Yes () No

Are there any cigarette smokers in the household? () Yes () No

Does your child always wear a helmet when riding his/her bicycle? () Yes () No

Is there anything else about this child you would like to discuss with the doctor? _____

Signed: _____ Date: _____
(Name/Relationship to Patient)

Reviewed by: _____ Date: _____