OC Pediatrics Medical Group, Inc.

DEMOGRAPHICS

Date Completed: _____

Patient's Full Name:_____

Date of Birth: _____ Gender: □ M □ F

Home Address:_____ City:_____ Zip:_____

Primary Phone: _____ Primary E-mail: _____

for patients 12 years and older please provide the patient's phone #: _____

Mother/Guardian's Name:_____ Date of Birth:_____

Home Address (if different from above):_____ City:_____ Zip:_____

Primary Phone:_____ Work Phone: _____ E-mail:_____

Father/Guardian's Name:_____ Date of Birth:_____

Home Address (if different from above):_____ City:_____ Zip:_____

Primary Phone:_____ Work Phone: _____ E-mail:_____

This child lives with: □ Mother only □ Father only □ Mother/Father □ Grandparent/Other

Race: □ American Indian or Alaskan Native □ Black or African-American □ Asian □ White □ Declined to specify

Ethnicity: □ Unknown □ Hispanic or Latino □ Not Hispanic or Latino □ Declined to specify

Preferred Language: _____ **Do you need a translator?** □ Yes □ No

Emergency Contact (not living with you):

Name:_____ Relationship: _____ Primary Phone: _____

Preferred Pharmacy Address:_____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize OC Pediatrics Medical Group, Inc. to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school and camp forms. I authorize payment directly to OC Pediatrics Medical Group, Inc. for any and all medical benefits otherwise payable to me under the terms of my insurance**. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits**. I also understand that I am responsible for advising OC Pediatrics Medical Group, Inc. of any changes to my insurance. Payment of co-pays are due on date of service.

Signature: _____ Relationship: _____ Date: _____

OC Pediatrics Medical Group, Inc.

PAST MEDICAL HISTORY

Prenatal & Birth History

During the pregnancy did mother: Smoke: □ No □ Yes Drink alcohol: □ No □ Yes Use drugs: □ No □ Yes Medications: □ No □ Yes	Pregnancy was: □ Uncomplicated □ Gestational Diabetes □ Hypertension □ Pre-Eclampsia □ Fetal Abnormalities □ Other:_____
Location of delivery: _____ (Name of Hospital/Birthing Center) Was the delivery: □ Spontaneous Vaginal □ C-Section □ Other (forceps, vacuum) Reason:_____	Gestational Age: _____ weeks Birth weight: _____ lbs _____oz Birth length: _____in Discharged with mother? □ Yes □ No If No, please explain: _____
Newborn History: □ Unremarkable □ Jaundice □ Respiratory problems □ Heart problems □ Hypoglycemia	Hearing test: □ Pass □ Refer CCHD (Critical Congenital heart Defects): □ Pass □ Refer

Past History

Any existing medical problems?	□ No □ Yes Explain _____
Any previous hospitalizations? (age/reason)	□ No □ Yes Explain_____
Any surgeries? (age/procedure)	□ No □ Yes Explain_____
Serious Injuries/Accidents?	□ No □ Yes Explain_____
Is your child on any current medications?	□ No □ Yes Explain_____
Asthma?	□ No □ Yes Explain_____
Allergies (seasonal, environmental, food or medication)?	□ No □ Yes Explain_____
Chicken Pox?	□ No □ Yes Explain_____
Chronic skin conditions (eczema, acne)?	□ No □ Yes Explain_____
Frequent ear infections?	□ No □ Yes Explain_____
Diabetes?	□ No □ Yes Explain_____
Heart problem/Heart murmur?	□ No □ Yes Explain_____
UTI?	□ No □ Yes Explain_____
Other: _____	

Patient Name: _____ Date of Birth: _____

OC Pediatrics Medical Group, Inc.

Mother: Age: _____ Height: _____ Current or past health problems:_____	Father: Age: _____ Height: _____ Current or past health problems:_____

Family History

Are there any cultural or religious practices that might affect your child's medical care (ex. Blood transfusion, dietary rules, etc.)? □ No □ Yes

Explain_____

		Mother	Father	Sibling	Grandparents	Other
Asthma?	□ No □ Yes	□	□	□	□	□
Allergies?	□ No □ Yes	□	□	□	□	□
Heart disease?	□ No □ Yes	□	□	□	□	□
High blood pressure?	□ No □ Yes	□	□	□	□	□
Skin disorders?	□ No □ Yes	□	□	□	□	□
Thyroid disease?	□ No □ Yes	□	□	□	□	□
Diabetes?	□ No □ Yes	□	□	□	□	□
Hearing loss?	□ No □ Yes	□	□	□	□	□
Cancer?	□ No □ Yes	□	□	□	□	□

Other: _____

_____

_____

Any other concerns you would like to discuss: _____

_____

_____

_____ _____ _____

Parent Signature Parent Name (Print) Date

Patient Name: _____ Date of Birth: _____