Meet and Greet/New Patient Registration Form

****Please fill out this entire form ***in full***. Any missing information may cause a delay in scheduling an appointment for your child with our office.

Please **print in block or capital letters.**

Parent 1 (Main contact for child)

Relation to Patient(s): ______________________________

Name: ______________________________ Date of birth: ______________

Cell Phone: ____________________ Home Phone: ____________________

Parent's email: ______________________________

Employer: ______________________________

Occupation: ______________________________

Lives with patient? ☐Yes ☐No Address if different from patient or other parent:

____

(Street) (Apartment #) (City) (State & Zip)

Parent 2

Relation to Patient(s): ______________

Name: ______________________________ Date of birth: ______________

Cell Phone: ____________________ Home Phone: ____________________

Parent's email: ______________________________

Employer: ______________________________

Occupation: ______________________________

Lives with patient? ☐Yes ☐No Address if different from patient or other parent:

____

(Street) (Apartment #) (City) (State & Zip)

Patient's Mailing Address: ____

(Street) (Apartment #)

____

(City) (State & Zip)

Primary Phone Number: ____________________ Is this a cell or home #? ______________

Does it belong to mom or dad? ______________

Secondary Phone Number (**required**): ______________ Is this a cell or home #? ____________

Who does it belong to? ______________________________

Children (please list all children in family that will be coming to our office for care)

Name (First and last)	Gender (M/F)	Date of Birth (Mo/Day/Year)

If Mother is Pregnant:

Mother's OB/Gyn:______________________________
Place of Delivery:______________________________
Baby's Expected Due Date: ______________ Baby's Gender (if known): __________
Baby's First Name (if known): ______________________________
Baby's Last Name: ______________________________

Insurance the child(ren) will be covered under while attending our office for care:

****** Please give copy of your insurance card(s) and photo ID to the front desk******

Name of Primary Insurance:______________________________

Policy Holder's Name:______________________ Policy Holder's Date of Birth:__________

Policy Holder's SSN (**required** if you would like us to bill your insurance company on your behalf): __________

Insurance ID#:______________________ Insurance Group#: __________

Mother's Maiden Name (some insurance companies and hospitals require this): __________

Health History-REQUIRED!

Please answer the following questions for *all* of your children:

1. Do you believe in vaccinating your children?______________________________

2. Are your children current on their vaccines?______________________________

3. Approximate date of last well visit for each of your children (month & year):______________________________

____

4. Preferred appointment date once you have transitioned to our practice? ______________________________

5. What type of appointment(s) are needed? (Ex: well or sick visit) ______________________________

6. How did you hear about our practice? ______________________________

7. Do any of your children have any chronic condition(s) such as diabetes, asthma, or allergies? Y/N

If yes, list children's names & condition(s):____

____

8. Are any of your children seeing a specialist? Please list children's names, provider's name, reason, and approximate dates of service: ____

____

9. **Are any of your children taking medication routinely for any reason? Y/N**

Please list children's names, the name of the medication they are taking, and what the medication is for:

____

____

10. **Do any of your children see or have they seen a therapist or counselor for any reason? Y/N**

Please list children's names, provider's name, reason, and approximate dates of service: ______________

____

11. **Have any of your children ever been hospitalized for any reason? Y/N**

Please list children's names, reason, and approximate date(s):_______________________________________

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12. **Any other information (medical or otherwise) that you would like our practice to be aware of?**

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In order for us to best care for your child, our office requires your child's medical records to be sent to us and reviewed <u>*before* any appointment can be scheduled</u>. It is extremely important to have an up to date immunization record, accurate growth charts, and up to date documentation of any chronic conditions. These records can be sent to us via mail, fax, or email to office@aakidspediatrics.com. You can also obtain the records yourself and give us a copy. If you need help obtaining your records, contact us and we will be happy to assist.

Name of person filling out this form (print):____

Signature:____ **Relation to patient:**__________________

Date:___________________________