Ronald A. Nagel, M.D., F.A.A.P.
Judith G. Weiner, M.D., F.A.A.P.
Kimberly Z. Diamond, M.D., F.A.A.P.
Lauren R. Crosby, M.D., F.A.A.P.
Autumn R. Shurin, M.D., F.A.A.P.

DATE COMPLETED:__________________________
PHYSICIAN: __________________________________

PATIENT REGISTRATION FORM

Please complete in full – Thank you

PERSONAL DATA:

CHILD'S NAME: ____ DOB:____________ SEX: ______
(Last) (First) (Middle)

ADDRESS:____ CITY:_______________________________________

STATE: _______ ZIP:______________ HOME PHONE:_______________________

PARENT #1 NAME: ______________________________ Date of Birth:___________________

Occupation: ______________________________Employer: ____

Email Address:____ Cell #:__________________________________

PARENT #2 NAME: ______________________________Date of Birth:___________________

Occupation: ______________________________Employer: ____

Email Address:____ Cell #:___________________________________

SIBLINGS:

Name	Date of Birth	Name	Date of Birth

EMERGENCY CONTACT ____ PHONE_______________________

INSURANCE INFORMATION:

Name of Insurance
Company:____

Who is the Policy Holder? ____DOB: ___________________________

ID #: ____ Group #:____

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MEDICAL HISTORY

NAME: ____

DATE OF BIRTH:____________________________________

PLACE OF BIRTH:___________________________________

ALLERGIES:_______________________________________

BIRTH WEIGHT:____________________________________

BIRTH LENGTH:____________________________________

PROBLEMS: (E.G. JAUNDICE, PREMATURITY)

____

____

FAMILY HISTORY:

DIABETES	**YES**	**NO**	**COMMENTS**____
SEIZURES	**YES**	**NO**	**COMMENTS**____
ALLERGIES	**YES**	**NO**	**COMMENTS**____
TUBERCULOSIS	**YES**	**NO**	**COMMENTS**____
HEART DISEASE	**YES**	**NO**	**COMMENTS**____
HIGH BLOOD PRESSURE	**YES**	**NO**	**COMMENTS**____
STROKE	**YES**	**NO**	**COMMENTS**____
ELEVATED CHOLESTEROL	**YES**	**NO**	**COMMENTS**____
CANCER	**YES**	**NO**	**COMMENTS**____

Thank you for taking the time to complete this information. Please notify your physician of any changes in your child’s health at each visit. Please notify our front office staff of any changes in your personal data so that we may keep our record current

DEVELOPMENTAL HISTORY (if applicable)
At what ages did the following occur?

Sat up without help _____________
Crawled ______________________
Walked _______________________
Spoke 1st words________________
Put words together _____________

Fed Self _____________
Bladder Control _____________
Bowel Control _____________
Dressed Self _____________

Were there any periods when your child quit talking? ____
Was child breast or bottle fed?_____________ Any problems?____
Did your child have problems with an exaggerated Gag Reflex? ____
Does child have any motor or coordination difficulties?(i.e. throwing/catching a ball, riding a bike, jumping) Please list and describe:____

HEALTH AND MEDICAL HISTORY (if applicable)

Childhood Illnesses (Fill in circle if yes-note frequency & age)

O Ear Infections _______________________
O Tonsillitis __________________________
O Frequent Colds ______________________
O Tubes in Ears_________________________________
O High Fevers __________________________________
O Respiratory Infections __________________________
O Allergies (to what?)____
O Seizures (when was last one?)____

Please list and describe any other important injuries, illnesses and major operations and when they happened.
____
____
____

Please list medications child is currently taking and what they are being taken for:

Name of Medication	For What
_________________________	_______________________
_________________________	_______________________
_________________________	_______________________

Has your child been to a neurologist? ___________ If yes, whom & results:___________________________________
____

What other therapies are your child receiving?
____
____

Has vision been examined? _______ Date: ___________ Results:___________________________
Does child wear glasses? ________ At what age were they prescribed? ____________
Has hearing been tested? ________ Date: ___________ Results: ___________________________
Does child wear hearing aid? _______ At what age was it prescribed? ____________

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