Patient Information – Additional Children

Additional Child's Information:

Last Name: _____ First Name:_____

Middle Initial:_____ Preferred Name:_____

Date of Birth:_____ Gender (circle): Male I Female SSN:_____

Primary Language (circle): English I Spanish I French I Other:_____

Ethnicity (circle): Hispanic I Non-Hispanic I Unknown

Race (circle): American Indian/Alaskan I Asian I Black I White I Other:_____

Additional Child's Insurance Information:

Subscriber's Last Name:_____ First Name:_____ Middle Initial: ___

Gender (circle): M I F Date of Birth:_____ Relationship to Subscriber:_____

Insurance Company:_____ Policy # : _____ Group # :_____

Co-pay Amount: _____ Secondary Insurance (circle): Yes I No

Additional Child's Birth Information:

Hospital:_____ City:_____ Obstetrician:_____

Birth Weight:_____ Birth Length: _____ Type of Feeding: _____

Birth Gestational Age: _____ Jaundice requiring treatment (circle): Yes I No

Complications of Pregnancy, Labor, or Delivery (describe): _____

_____

Additional Child's Past History:

Previous Medical Problems: Please list significant past medical problems. _____

_____

_____

Chronic Medications: Please list the child's dose and frequency of medication. _____

_____

_____

Allergies: Please list any drug and/or food allergies and reaction. _____

_____

Surgeries: Please list any past surgeries and dates. _____

_____

Hospitalizations: Please list any past hospitalizations and dates. _____

_____

Additional Child's Social History:

Who lives in the household? _____

Does anyone in the household smoke? (circle) Yes I No If yes, (circle) Inside or Outside?

If the child is 13 or older, does the child smoke? (circle) Yes I No

Are the child's biological parents married? (circle) Yes I No If no, what is the custody arrangement?_____

Does the child attend daycare? (circle) Yes I No If yes, where?_____

Does this “Additional Child” have the same Parents/Guardians as “Child 1”? (circle) Yes | No

If “Yes” then skip the remainder of this page. If “No”, please complete the following based on the “Additional Child’s” Parents/Guardians:

Family History: Please indicate with an X the specified relatives with any of the following conditions.

Diagnosis	None	Mom	Dad	Sibling	Mom’s Mom	Mom’s Dad	Dad’s Mom	Dad’s Dad	Other
ADD									
Alcohol/Drug Abuse									
Anemia									
Anxiety									
Asthma									
Birth Defect (type?)									
Bleeding/Clotting Disorder									
Cancer (type?)									
Cholesterol Problem									
Depression									
Developmental Delay									
Diabetes									
Foster Care									
Heart Disease									
Stroke									
Tuberculosis									
Other									

Details from above:
Other relevant personal or family history: