Fox Chase Pediatrics

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
LAST NAME:	FIRST NAME:	MIDDLE NAME:	
DATE OF BIRTH:	SEX:		
STREET ADDRESS:			APT:
CITY:	STATE:	ZIP:	
PRIMARY PHONE:	WHOSE PHONE IS THIS? (Patient, Parent, Legal Guardian, other):		
EMAIL:			

RESPONSIBLE PARTY (Parent/Legal Guardian who is responsible for the bill)			
LAST NAME:	FIRST NAME:	DATE OF BIRTH:	
RELATIONSHIP TO PATIENT (Mother/Father/Step-Parent/Guardian, etc.):			
STREET ADDRESS:			APT:
CITY:	STATE:	ZIP:	
CELL PHONE:	OCCUPATION:	EMPLOYER:	
EMAIL:			

OTHER RESPONSIBLE PARTY (Parent/Legal Guardian who is responsible for the bill)			
LAST NAME:	FIRST NAME:	DATE OF BIRTH:	
RELATIONSHIP TO PATIENT (Mother/Father/Step-Parent/Guardian, etc.):			
STREET ADDRESS:			APT:
CITY:	STATE:	ZIP:	
CELL PHONE:	OCCUPATION:	EMPLOYER:	
EMAIL:			

EMERGENCY CONTACT (Person other than Parent/Legal Guardian)		
LAST NAME:	FIRST NAME:	PHONE:
RELATIONSHIP TO PATIENT (Mother/Father/Step-Parent/Guardian, etc):		

PHARMACY INFORMATION		
PHARMACY NAME:		
STREET ADDRESS:		
CITY:	STATE:	ZIP:
PHONE:		

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DATE OF BIRTH PATIENT LAST, FIRST NAME

PATIENT REGISTRATION FORM CONTINUED

PRIMARY INSURANCE		
INSURANCE COMPANY NAME:	ID#:	Group#:
NAME OF INSURED:		

SECONDARY INSURANCE (If Applicable)		
INSURANCE COMPANY NAME:	ID#:	Group#:
NAME OF INSURED:		

By signing below, I authorize the release of all medical information necessary to process claims, and I authorize payment to Fox Chase Pediatrics.

Signature Date

Fox Chase Pediatrics

DATE OF BIRTH PATIENT LAST, FIRST NAME

MEDICAL HISTORY

FAMILY MEMEBER			
	NAME	**BIRTH DATE**	**SERIOUS ILLNESS**
MOTHER			
FATHER			
BROTHER/SISTER			
BROTHER/SISTER			
BROTHER/SISTER			
BROTHER/SISTER			
BROTHER/SISTER			
BROTHER/SISTER			

FAMILY HISTORY (Check all that apply):

□ ADHD
□ Anemia
□ Anxiety
□ Asthma
□ Autism
□ Bleeding Disorders
□ Cardiovascular Disease (under 50)
□ Celiac Disease
□ Congenital Heart Disease
□ Developmental Delay
□ Epilepsy/Seizures
□ Food Allergy
□ Gastrointestinal/ Irritable Bowel Syndrome
□ Hearing Loss
□ High Blood Pressure
□ High Cholesterol
□ Hip Dysplasia
□ Lazy Eye
□ Learning Disorder
□ Mental Illness
□ Migraines
□ SIDS (Sudden Infant Death Syndrome)
□ Type 2 diabetes
□ Other:

PATIENT'S ALLERGIES	
FOOD:	
MEDICATION:	

PATIENT'S HOSPITALIZATIONS / SURGERY			
DATE	**AGE**	**HOSPITAL**	**REASON**

Fox Chase Pediatrics

DATE OF BIRTH PATIENT LAST, FIRST NAME

CHILD'S PROBLEM LIST / SERIOUS ILLNESSES (to be completed by the physician)			
DATE	**PROBLEM ILLNESS**	**DATE**	**PROBLEM ILLNESS**

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