Children's Medical Clinic of Santa Barbara

15 E. Arrellaga • Santa Barbara, CA 93101
PHONE 805/965-1095

Date:

NEW PATIENT QUESTIONNAIRE TO BE FILLED OUT BY PARENT OR GUARDIAN

FAMILY INFORMATION

CHILD'S LEGAL/INSURED NAME (last/first/middle)	Sex
Place of Birth	Date of birth
Child lives with:	

PARENT'S NAME (last/first/middle)		
Date of Birth	Place of Birth	SS#
Address		
City/State/Zip		
Home Phone	Cell Phone	
Occupation	Driver's License No./State	
Employer	Phone	

PARENT'S NAME (last/first/middle)		
Date of Birth	Place of Birth	SS#
Address (if different)		
City/State/Zip		
Home Phone	Cell Phone	
Occupation	Driver's License No./State	
Employer	Phone	

GUARDIAN (If other than parent)(last/first/middle)		
Relationship	SS#	
Address		
City/State/Zip		
Home Phone	Cell Phone	
Occupation	Drivers License No./State	
Employer	Phone	

INSURANCE INFORMATION

HAVE YOU ADDED YOUR CHILD TO YOUR INSURANCE POLICY?_____

A COPY OF YOUR INSURANCE CARD IS REQUIRED.

HAVE YOU GIVEN US YOUR INSURANCE CARD?_____

HAVE YOU RECEIVED THE CLINIC NOTICE OF PRIVACY PRACTICES?_____

I hereby give my consent for my child to receive treatment from the physicians of Children's Medical Clinic of Santa Barbara, Inc.

I have received, read and agreed to the Clinic's financial policy.

I am aware that my insurance may not cover the full cost of services received and agree to accept responsibility for any noncovered services. I agree to notify the business office of changes in insurance or my address and to inform the doctor or other personnel if preauthorization is necessary for referrals and hospital admission.

I request that payment of authorized benefits be made to Children's Medical Clinic of Santa Barbara, Inc. I authorize any holder of medical information about my child to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

X _____

SIGNATURE DATE

PERSON TO CONTACT IN AN EMERGENCY

Home Phone Cell Phone

PARENTS ARE:
Δ Married Δ Divorced Δ Remarried Δ Separated Δ Single

OTHERS IN THE HOME (name/age/relationship)

1. _____
2. _____
3. _____
4. _____

Who cares for the child during the day or after school?

FORM CAN BE SUBMITTED TO frontdesk@childrenssb.com

BIRTH HISTORY

Did the child's mother have any illnesses or problems (other than morning sickness) during her pregnancy, labor, delivery or take any medications?

	Δ Yes	Δ No	Δ Don't Know
Was the baby premature?	Δ Yes	Δ No	Δ Don't Know
Was the baby delivered by Caesarean?	Δ Yes	Δ No	Δ Don't Know
Baby have any problems breathing at birth?	Δ Yes	Δ No	Δ Don't Know
Did the baby develop jaundice? (yellowing)	Δ Yes	Δ No	Δ Don't Know
Did the baby have a seizure? (convulsion)	Δ Yes	Δ No	Δ Don't Know
Did the baby have any other problems at birth or in the first few weeks of life?	Δ Yes	Δ No	Δ Don't Know
Was your baby's discharge delayed for any reason	Δ Yes	Δ No	Δ Don't Know

Birth weight af baby_____ lbs. _____ ozs.

FAMILY HISTORY

Have any family members had these conditions?

Birth defect/deformity	Δ Yes	Δ No	Δ Don't Know
Mental illness/retardation	Δ Yes	Δ No	Δ Don't Know
Convulsions/seizures	Δ Yes	Δ No	Δ Don't Know
Family or inherited diseases	Δ Yes	Δ No	Δ Don't Know
Serious or fatal childhood illness	Δ Yes	Δ No	Δ Don't Know
Eye or hearing problems	Δ Yes	Δ No	Δ Don't Know
Asthma, hay fever, eczema, allergies	Δ Yes	Δ No	Δ Don't Know
Tuberculosis	Δ Yes	Δ No	Δ Don't Know
Diabetes	Δ Yes	Δ No	Δ Don't Know
Thyroid disease	Δ Yes	Δ No	Δ Don't Know
Heart attacks under age 50	Δ Yes	Δ No	Δ Don't Know
Heart disease at birth	Δ Yes	Δ No	Δ Don't Know
High cholesterol	Δ Yes	Δ No	Δ Don't Know
High blood pressure	Δ Yes	Δ No	Δ Don't Know
Peptic ulcer	Δ Yes	Δ No	Δ Don't Know
Kidney problem	Δ Yes	Δ No	Δ Don't Know
Blood/bleeding diseases, Sickle Cell Anemia	Δ Yes	Δ No	Δ Don't Know
Accidental Poisoning	Δ Yes	Δ No	Δ Don't Know
Smoke regularly	Δ Yes	Δ No	Δ Don't Know
Drinking problem	Δ Yes	Δ No	Δ Don't Know
Drug problem	Δ Yes	Δ No	Δ Don't Know
Other health problems	Δ Yes	Δ No	Δ Don't Know
Explain	Δ Yes	Δ No	Δ Don't Know

DEVELOPMENT

The child: sat alone at _____months

Walked alone at _____months

Toilet trained at _____months

Said first word at _____months

Said two-word sentences at _____months

The child's:

General health is	Δ Above average	Δ Average	Δ Below Average
Physical development	Δ Above average	Δ Average	Δ Below Average
Emotional development	Δ Above average	Δ Average	Δ Below Average
Coordination	Δ Above average	Δ Average	Δ Below Average
Activity level	Δ Above average	Δ Average	Δ Below Average

In just a few words , how would you describe your child? _____

HEALTH HISTORY

Has your child ever had or now have...

Allergies to Medication	Δ Yes	Δ No	Δ Don't Know
Chicken Pox	Δ Yes	Δ No	Δ Don't Know
Scarlet Fever	Δ Yes	Δ No	Δ Don't Know
Rheumatic Fever	Δ Yes	Δ No	Δ Don't Know
Tuberculosis or positive TB test	Δ Yes	Δ No	Δ Don't Know
Hepatitis	Δ Yes	Δ No	Δ Don't Know
Surgery or operation	Δ Yes	Δ No	Δ Don't Know
Hospitalization	Δ Yes	Δ No	Δ Don't Know
Eye or vision problems	Δ Yes	Δ No	Δ Don't Know
Ear or hearing problems	Δ Yes	Δ No	Δ Don't Know
Dental problems	Δ Yes	Δ No	Δ Don't Know
Speech problems	Δ Yes	Δ No	Δ Don't Know
Recurrent sore throat or tonsillitis	Δ Yes	Δ No	Δ Don't Know
Bronchitis	Δ Yes	Δ No	Δ Don't Know
Wheezing or asthma	Δ Yes	Δ No	Δ Don't Know
Allergic problems	Δ Yes	Δ No	Δ Don't Know
Frequent runny nose	Δ Yes	Δ No	Δ Don't Know
Recurrent nosebleeds	Δ Yes	Δ No	Δ Don't Know
Recurrent skin rashes or eczema	Δ Yes	Δ No	Δ Don't Know
Stomach or bowel problems	Δ Yes	Δ No	Δ Don't Know
Hernia	Δ Yes	Δ No	Δ Don't Know
Bedwetting	Δ Yes	Δ No	Δ Don't Know
Urine / kidney problems / infections	Δ Yes	Δ No	Δ Don't Know
Anemia or blood problems	Δ Yes	Δ No	Δ Don't Know
Heart condition	Δ Yes	Δ No	Δ Don't Know
High blood pressure	Δ Yes	Δ No	Δ Don't Know
Fainting spells	Δ Yes	Δ No	Δ Don't Know
Joint pain or swelling	Δ Yes	Δ No	Δ Don't Know
Bone problems / fractures	Δ Yes	Δ No	Δ Don't Know
Convulsions / seizures	Δ Yes	Δ No	Δ Don't Know

Any Additional Comments:_____

Any Additional information you believe the doctor should know: