FLATIRON PEDIATRICS
PORT WASHINGTON

PATIENT INFORMATION

Patient First Name: _____ Last Name: _____

D.O.B: _____/_____/_____ Legal Sex: _____

Mailing Address:_____
(Street or P.O. Box). (City) (State & Zip)

Cell phone: (_____) _____ - _____

Caregiver #1 First Name_____ Last Name: _____

Cell phone: (_____) _____-_____

Email: _____

Caregiver #2 First Name_____ Last Name: _____

Cell phone: (_____) _____-_____

Email: _____

Preferred Pharmacy: _____

Address:_____

Phone number: (_____) _____-_____

Flatiron Pediatrics
Port Washington

Insurance Information:

Primary Insurance Policy Holder Info:

Name: _____ Relation:_____ DOB_____

Primary Insurance: _____ ID: _____

Group #: _____Insurance Contact#:_____

Insurance Address: _____
(Street or P.O. Box). (City) (State & Zip)

Secondary Insurance Policy Holder Info:

Name: _____Relation: _____ DOB _____

Secondary Insurance: _____ ID: _____

Group #: _____Insurance Contact #: _____

Insurance Address: _____
(Street or P.O. Box) (City) (State & Zip)

Name of Sibling 1: _____ Date of Birth: _____

Name of Sibling 2: _____ Date of Birth: _____

Name of Sibling 3: _____ Date of Birth: _____

Name of Sibling 4: _____ Date of Birth: _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes please explain and provide s copy of any legal paperwork that support this restriction:

_____

_____

Signature of Caregiver_____ Date_____

Flatiron Pediatrics
Port Washington

Birth History:

Hospital: _____ Obstetrician: _____

Type of Delivery: _____ Complications: _____

Type of feeding: _____ Birth Weight: _____

Discharge weight: _____ Blood Type: _____

Family History:

Anemia: _____ Asthma:_____ Birth Defect: _____

Cancer: _____ Convulsions: _____ Diabetes: _____

Heart Disease: _____ Kidney Disease: _____ Tuberculosis: _____

Learning Issues / Disabilities: _____

Vision, Speech, Hearing Issues: _____

Allergies: _____ Other: _____

Child's Previous History:

Previous Doctor: _____ Address: _____

Childhood Illness: _____

Allergies: _____ Latex Allergy?: _____

Any operations: _____

Behavioral difficulties: _____

Other: _____

_____

How did you hear about Flatiron Pediatrics? _____

Can Flatiron Pediatrics email you to participate in a survey? YES / NO

If yes please provide email address: _____

Signature of Parent or Guardian: _____

Date: _____