Flatiron Pediatrics

☎ 212 460-5600
888 526-5461
inquiry@flatironpediatrics.com
27 East 22nd Street, New York, NY 10010

PATIENT INFORMATION

Patient First Name: _____ ***Last Name:*** _____
D.O.B: _____/_____/_____ ***Sex: M*** _____ ***F*** _____

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

Home phone: (_____) _____ - _____

Father's First Name _____ ***Last Name:*** _____
D.O.B: _____/_____/_____ ***SS#:*** _____-_____-_____
Primary phone: (_____) _____-_____
Home phone: (_____) _____-_____
Work phone :(_____) _____-_____
Cell phone: (_____) _____-_____
Email: _____
Employer Name: _____

Mother's First Name: _____ ***Last Name:*** _____
D.O.B: _____/_____/_____ ***SS#:*** _____
Primary phone: (_____) _____-_____ *(if different from father)*
Home phone: (_____) _____-_____
Work phone: (_____) _____-_____
Cell phone: (_____) _____-_____
Email: _____
Employer Name: _____

Preferred Pharmacy:
Name: _____
Address: _____
Phone number: (_____) _____-_____

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Insurance:

Primary Policy: *Holder's Name* _____

Primary Insurance: _____ ***ID:*** _____

Group #: _____***Insurance Contact#:*** _____

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

Secondary Policy: *Holder's Name:* _____

Secondary Insurance: _____ *ID:* _____

Group #: _____*Insurance Contact #:* _____

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

Name of Siblings: _____ *Date of Birth*: _____
_____ _____
_____ _____

Name of person caring for child (*if different from parent)*

_____

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:
_____

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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 Problem: _____
Vision, Speech, Hearing Problem: _____
Allergies: _____ *Other:* _____

Childs Previous History:

Previous Doctor: _____ *Address:* _____
Childhood Illness: _____
Allergies: _____ *Latex Allergy:* _____
Any operations: _____
Behavioral difficulties: _____
Other: _____

Who referred you to ***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: _____