

Raybon Pediatrics

700 Zeagler Dr., Ste 7

Ph: 386-385-8137/Fax: 386-487-2113

Child 1: Last Name: _____ First Name: _____ MI: _____
D.O.B.: ____/____/____ Sex: _____ Primary Language: _____
Ethnicity: _____ Race: _____
Social Security Number: ____-____-_____

Insurance Information

Primary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Sex: _____
Insurance Carrier: _____ Policy ID#: _____
Group #: _____

Secondary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's SSN: ____-____-_____
Insurance Carrier: _____ Policy ID#: _____
Group #: _____

Child 2: Last Name: _____ First Name: _____ MI: _____
D.O.B.: ____/____/____ Sex: _____ Primary Language: _____
Ethnicity: _____ Race: _____
Social Security Number: ____-____-_____

Insurance Information

Primary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Sex: _____
Insurance Carrier: _____ Policy ID#: _____
Group #: _____

Secondary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's SSN: ____-____-_____
Insurance Carrier: _____ Policy ID#: _____
Group #: _____

Required Information

Mailing Address: _____
(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____

Who lives at this household? _____

(Please note, this information is being requested to improve intake of your child's Social History.)

Contact Information

Contact 1: Name: _____ Date of Birth: ____ / ____ / ____
Lives with patient? _____ If no, please list contact's address: _____
Contact's phone #: _____ Cell Work Home
Social Security Number: ____ - ____ - ____
Relation to Patient: _____ Biological Relation to Patient: _____
(Please note, this information is being requested to improve intake of your child's Family Medical History.)
Home or Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____
Preferred Email: _____ Home Email Work Email
How would this contact ideally prefer to be contacted regarding :

- Appointment Reminders:**
- Recall Notices:**
- General Practice Notices:**
- Patient Portal Notifications:**

Contact 2: Name: _____ Date of Birth: ____ / ____ / ____
Lives with patient? _____ If no, please list contact's address: _____
and Contact's phone #: _____ Cell Work Home
Social Security Number: ____ - ____ - ____
Relation to Patient: _____ Biological Relation to Patient: _____
(Please note, this information is being requested to improve intake of your child's Family Medical History.)
Home or Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____
Preferred Email: _____ Home Email Work Email
How would this contact ideally prefer to be contacted regarding :

- Appointment Reminders:**
- Recall Notices:**
- General Practice Notices:**
- Patient Portal Notifications:**

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ Phone: (____) ____ - ____
2: _____ Relationship _____ Phone: (____) ____ - ____

Additional Contact Questions:

Who should receive billing statements? _____
May all contacts have access to the patient's records electronically?
If no, list who may have access: _____

*****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?

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Patient History Information

If completing for more than 1 child, please indicate which child for each item

Completed by: _____ Date Completed: _____

Does your child have any on-going medical issues?

1. _____

(Diagnosis)
(Date)

 Details: _____

2. _____

(Diagnosis)
(Date)

 Details: _____

3. _____

(Diagnosis)
(Date)

 Details: _____

Has your child ever been Diagnosed with any of these: (please indicate which child & when)

Yes		when/who
<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	Anemia/Sickle Trait	
<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	Bleeding disorder	
<input type="checkbox"/>	Bedwetting >10 y/o	
<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Cystic Fibrosis	
<input type="checkbox"/>	Developmental Delay	
<input type="checkbox"/>	Diabetes, Childhood	
<input type="checkbox"/>	Ear Problems	
<input type="checkbox"/>	Eczema/Skin probs	

Yes		when/who
<input type="checkbox"/>	Epilepsy/Seizures	
<input type="checkbox"/>	Genetic Disorder	
<input type="checkbox"/>	Heart Dz <55 y/o	
<input type="checkbox"/>	Hi Cholesterol/Trigs	
<input type="checkbox"/>	Immune Probs, HIV	
<input type="checkbox"/>	Kidney Disease	
<input type="checkbox"/>	Liver Disease	
<input type="checkbox"/>	Mental: Depression/ ADHD/ Bipolar, etc	
<input type="checkbox"/>	Migraines/headaches	
<input type="checkbox"/>	Stomach/GI prob	
<input type="checkbox"/>	*OTHER	

Allergy / Reaction Information

Medication Allergies: No: _____ Yes: ____ (explain below)

- 1: _____

(Medication)
(Reaction)
(Age)

- 2: _____

(Medication)
(Reaction)
(Age)

Non-Medication Allergies: None: ____ Yes (please list): _____

Vaccine Reactions: None: ____ Yes (please list): _____

Surgeries?

No: _____ Yes: _____

Pertinent Past Medical History

(if Yes then provide details including age, year or date)

When & Why:

No **Serious Injuries** Please list, with dates:
Yes

No **Hospitalizations** When & Why:
Yes

Specialists your child has seen (name, office location, when/why):

Current/On-going Medications

1.	_____	(Medication)	(Dose)	(Date Started)	(Child's Name)
2.	_____	(Medication)	(Dose)	(Date Started)	(Child's Name)
3.	_____	(Medication)	(Dose)	(Date Started)	(Child's Name)
4.	_____	(Medication)	(Dose)	(Date Started)	(Child's Name)

Pertinent Family Medical History: Does anyone on mother's or father's side have a history of:

{MGM=grandmother-mom's side; PGF=grandfather-dad's side; MGGM- great grandmother-mom's side), etc}

Y	N		relationship
		Addictions	
		Allergies	
		Anemia/Sickle Trait	
		Asthma	
		Bleeding disorder	
		Bedwetting >10 y/o	
		Cancer	
		Cystic Fibrosis	
		Developmental Delay/CP	
		Diabetes, Adult	
		Diabetes, Childhood	

Y	N		relationship
		Epilepsy/Seizures	
		Hearing Loss, childhood	
		High Blood Pressure	
		High Cholesterol/Triglycerides	
		Immune Problems, HIV	
		Kidney Disease	
		Liver Disease	
		Migraine headache	
		Depression.	
		Bipolar D/O or Schizophrenia	
		ADD or ADHD	

Other: _____

Pertinent Social History: Does anyone in your home smoke: Y N Do they smoke inside the home: Y N

Any Pets: Y N If yes, what kind? _____

Are both biological parents involved in child's life? _____

Name of Previous Physician, so we can request records: _____

How did you hear about Raybon Pediatrics? _____

Preferred Pharmacy: _____