New Patient Registration

Patient Name: ______________________________ Date of Birth: ________________

Race: ________________ Ethnicity: _____________ Primary Language: _______________

Parent 1 Name: ____________________________ Date of Birth: _________________

Address: __________________________________ Height: ______________________

__________________________________ Phone Number: _______________

Occupation: ________________________________ Email: _________________________

Parent 2 Name: _____________________________ Date of Birth: __________________

Address: __________________________________ Height: ______________________

__________________________________ Phone Number: _______________

Occupation: ________________________________ Email: _________________________

Sibling Name: _____________________________ Date of Birth: _______________

Sibling Name: ______________________________ Date of Birth: _______________

Medical History

Place of Birth: ________________________________ Birth Weight: __________________

Type of Delivery: ______________________________ Complications: _______________

Surgeries: _________________________________ Hospitalizations: ________________

____ _________________________________

Allergies: _____________________________________ Health Problems: _______________

____ _________________________________

Medications: ____

____

PLEASE TURN OVER TO COMPLETE

Family Medical History

Please indicate if any of the following family members have any health problems including but not limited to diabetes, heart disease, high blood pressure, high cholesterol, asthma, allergies, cancer (specific type), kidney disease, thyroid disease, deafness, seizures, clotting/bleeding disorders, etc.

	Living		History
Parent 1:	Yes	No	______________________
Parent 1 Grandfather:	Yes	No	______________________
Parent 1 Grandmother:	Yes	No	______________________
Parent 1 Aunt(s):	Yes	No	______________________
Parent 1 Uncle(s):	Yes	No	______________________
Cousin(s):	Yes	No	______________________

	Living		History
Parent 2:	Yes	No	______________________
Parent 2 Grandfather:	Yes	No	______________________
Parent 2 Grandmother:	Yes	No	______________________
Parent 2 Aunt(s):	Yes	No	______________________
Parent 2 Uncle(s):	Yes	No	______________________
Cousin(s):	Yes	No	______________________

Home Environment

Type of Home: House Apartment Other ______________________

Number of Bedrooms: ________ **Was your home built before 1965?** ______________

Water: City Well **Smokers at home:** Yes No **Guns at home:** Yes No

Who lives in household? ______________________________________

Parents: Married Never Married Divorced Separated

Carbon Monoxide Detectors: Yes No **Smoke Detectors:** Yes No

Pet(s) at home: ______________________

Type(s): ______________________

Safety

1. **Does your child use a car seat/booster seat or seatbelts if over the age of 8?**
   Yes No
2. **Does your child wear a helmet for biking, skating, skiing or riding a skateboard or scooter?**
   Yes No
3. **Has your child traveled outside of the U.S.?** Yes No If Yes, Where?
4. **Does your child have regular contact with a person in a nursing home, jail or with known Tuberculosis (TB)?**
   Yes No