

# Pediatric Associates Family Registration

Date: \_\_\_\_\_ Who referred you to Pediatric Associates? \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
 Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_  
 Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_

List All Children:	Birth Date	Sex	Name	Birth Date	Sex
_____	/ /	M F	_____	/ /	M F
_____	/ /	M F	_____	/ /	M F
_____	/ /	M F	_____	/ /	M F

Please circle any that apply to your household/home:

- |                           |                                    |                             |                      |
|---------------------------|------------------------------------|-----------------------------|----------------------|
| At least 1 parent smokes  | Children attend daycare/babysitter | Water heater set to < 120°  | Firearms in the home |
| Trampoline                | Home built before 1979             | Alcoholic beverages at home | Home swimming pool   |
| Smoke detectors           | Carbon monoxide detector           | Home "Baby proofed"         | 4-wheelers           |
| Recent separation/divorce | Recent change in residence         | Recent remarriage           |                      |

Please check any of the following conditions that occur in any relative and state the relationship.

Disease	Relationship to children	Disease	Relationship to children
<input type="checkbox"/> Alcoholism		<input type="checkbox"/> Heart attack before age 55	
<input type="checkbox"/> Allergies		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Anemia/blood disorders		<input type="checkbox"/> High cholesterol	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Learning disabilities	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Childhood Cancer		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Depression/Anxiety		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Eating disorders		<input type="checkbox"/> Other	

On behalf of the patient(s) listed above, I have been make aware of Pediatric Associates privacy policies and offered a written copy for my records.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give authorization for payment of insurance benefits to be made directly to Pediatric Associates. I understand that I am financially responsible for all charges whether or not they are covered by insurance and authorize this healthcare provider to release all information necessary to secure payment of benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_