Peds First Healthcare, LLC

Medical Intake Form

Child's Name (First)_____ (MI) _____ (Last)_____

DOB_____ Gender_____

Street Address_____

City_____ State_____ Zip Code _____

Previous PCP if transferring to PFH _____ PCP office phone #_____

Preferred Pharmacy (name)_____ Address _____

City_____ Phone #_____

Parent/legal guardian Name_____

Date of birth_____ Marital status ☐ Single ☐ Married ☐ Divorced/separated

Home address if different_____

Home phone number ( )_____ Cell number _( )_____

Email _____

Employer Name & address _____

Work phone number ( )_____

Emergency contact _____ Phone #_____

Primary Insurance Co._____ Policy holder _____

Secondary Insurance Co. _____ Policy holder_____

I authorize treatment and agree to pay all fees and charges for treatment promptly upon request. I hereby authorize the release of pertinent information to my insurance company. If my account becomes assigned to a collection agency, I agree to pay all costs of collection, including 25% agency fees, court costs, and attorney fees. If there is no insurance coverage, I agree to pay for the visit and any procedures/treatments at the time of visit.

Print name_____ Date_____

Signature (responsible party)_____

Patient Health Questionnaire

Food allergies ☐ Yes ☐ No

If yes, list _____

Drug allergies ☐ Yes ☐ No

If yes, list _____

Is your child taking any medications? ☐ Yes ☐ No

Please list all medications including meds that are given as needed:

_____ _____ _____

_____ _____ _____

Medical problems

Asthma	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No
Recurrent ear infections	☐ Yes	☐ No
Reflux	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Developmental Delay	☐ Yes	☐ No
Bladder/bowel problems	☐ Yes	☐ No
Prematurity (born less than 36 weeks gestation)	☐ Yes	☐ No
Psychiatric/Mental disorders	☐ Yes	☐ No

Other health conditions: _____

Serious illness or injuries_____

Surgeries_____

Birth history

Birth weight_____

Hospital of birth_____

Pregnancy, labor, or delivery complications ☐ Yes ☐ No

If yes, please explain_____

_____

Jaundice ☐ Yes ☐ No

Phototherapy ☐ Yes ☐ No

Passed the newborn hearing screen at birth ☐ Yes ☐ No

Received Hep B vaccine prior to discharge ☐ Yes ☐ No

Social history

Diet _____

Who lives with child?_____

Does child attend daycare or home babysitter? ☐ Yes ☐ No

Number of siblings and ages_____

Animals in the home ☐ Yes ☐ No

Does any household member smoke? ☐ Yes ☐ No

Family medical history (immediate family- i.e., patient's siblings, parents, grandparents)

Any major family health conditions not attributable to old age? i.e., cancer, asthma, mental illness, heart attack/stroke at an early age. List health condition and relationship to patient

_____-_____

_____ _____

_____ _____