**PEDIATRIC REGISTRATION**

Name: _____

Male/Female: _____ SSN: _____ Age: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail address: _____

Best way to reach you: □Home □Cell □Work Can we leave a message? □Y □N

Marital Status: □Married □Single □Separated □Divorced □Widowed

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Other □Declined

Race: □Am Indian □Asian □Black □White □Other □Declined

Preferred Language (*if other than English)*: _____

Emergency Contact/Relationship: _____ Phone: _____

Guarantor of Bill/Relationship: _____ Phone: _____

Insurance Carrier/Employer: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

**CONSENT FOR MEDICAL TREATMENT**

I _____, being legal guardian for _____, do give my
*Parent/Guardian* *minor*
consent for him/her to be medically treated by the physicians and staff of Lillington Family Medical Center. Additionally, the following person(s) aged 18 years or older have permission to bring my child named above to office visits without my presence.

**Name & Relationship of anyone <u>other than</u> the Parent/Guardian with permission to bring minor to an appointment:**

_____

_____

_____

_____

Parent/Guardian Signature Date Phone Number

**PEDIATRIC**

**PAST MEDICAL HISTORY**

Pharmacy/Location: _____

Chronic Medical Problems: _____

Current Medications: _____

_____

Drug Allergies: _____

Hospitalizations or Surgeries: _____

Please List Any Specialty Providers Your Child May See: _____

_____

**Birth History: (NEWBORN – 6 MONTHS ONLY)**

Week's Gestation: _____ Birth Weight: _____ Where Delivered: _____

Delivery Type: _____ Delivery Problems: _____

Neonatal Problems: _____

**VACCINE HISTORY (***when was your child's last…?) Please provide shot record if possible*

Tetanus (Tdap/Td): _____ Flu: _____

Gardasil (HPV): _____ Menactra (Meningitis): _____

**SOCIAL HISTORY**

Mother: _____ Occupation: _____

Father: _____ Occupation: _____

Smoking in the home? □Y □N School/Daycare: _____ Grade: _____

**Child lives with:**

□mother/father □mother/stepfather □father/stepmother □grandparents □foster parent/guardian

_____

*(please print name of guardian if child does not live with mother and father)*

| **FAMILY HISTORY** | | | *If yes, please list relationship, age diagnosed/at death, etc.* |
|---|---|---|---|
| Diabetes | Y | N | |
| Thyroid Disorder | Y | N | |
| Lung Disease<br>□*COPD* □*Emphysema*<br>□*Asthma* | Y | N | |
| Cancer *(what type?)* | Y | N | |
| Heart Disease | Y | N | |
| High Blood Pressure | Y | N | |
| Stroke | Y | N | |
| Kidney/Urinary Disease | Y | N | |
| Liver Disease | Y | N | |
| Gastrointestinal Disease | Y | N | |
| Alcoholism/Substance Abuse | Y | N | |
| Mental/Nervous Disorder | Y | N | |
| Other _____ | Y | N | |

Please list any other medical conditions that run in your family: _____

_____