TLC PEDIATRICS, PC d/b/a
REVERE-WINTHROP PEDIATRICS
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NEW PATIENT REGISTRATION FORM

Patient Name ____**DOB** _________________ [ ] Male [ ] Female

Legal Guardian(s) ____**Relationship** ________________

Address ____

Primary Phone ______________________ [ ]Home [ ]Cell [ ]Work [ ]Mom [ ]Dad [ ]Other_______________

Emergency Phone ___________________________ **Additional Phone** _______________________________
[ ] Home [ ] Cell [ ] Work (Mom/Dad) [ ] Home [ ] Cell [ ] Work (Mom/Dad)

Additional Address ____**Relationship** ____________

<u>Primary Insurance Co</u> _________________________**Member ID**___________________ **Grp ID**____________

Holder's Name ______________________________ **DOB** _______________ **Relationship** ______________

Address: (if different) ____

<u>Secondary Insurance</u> _________________________**Member ID**___________________ **Grp ID**____________

Holder's Name ______________________________ **DOB** _______________ **Relationship** ______________

Address (if different) ____

<u>SIBLINGS IN THE PRACTICE WITH THE **SAME** INSURANCE INFORMATION:</u>

Name ____DOB ________________________ [ ] M [ ] F

Name ____ DOB________________________ [ ] M [ ] F

Name ____ DOB ________________________ [ ] M [ ] F

How did you hear about us? [ ] Newspaper [ ] Yellow Pages [ ] Website/Internet

[ ] Friends/Relatives _______________________ **[ ] Others** ________________
Name

Patient's Name: ____ DOB: ____________________

MEDICAL HISTORY

Health Problems:
Current Medications:

Allergies: Medication: **Anaphylaxis: [ ] Yes [ ] No**
Food: **Epi-pen: [ ] Yes [ ] No**

I. Newborn History

Birth History
[ ] Full term _____ [ ] Premature _____weeks **Birth**: Weight ___ lbs ___oz Length _____in Head ____cm
Delivery: [ ] Vaginal [ ] C-section [ ] Instrument _____________ Hospital: _________________________
Labor: _______ hours [ ] Spontaneous [ ] Induced Presentation: [ ] Head [ ] Breech
Complication ____

Name and Location of OB/GYN ____

Feeding History
[ ] Breast [ ] Formula __________________________________
Problem: [ ] No [ ] Yes ____
Prenatal/Maternal History
Complication: [ ] No [ ] Yes ____
Medical Problem: [ ] No [ ] Yes ____
Medication:
[ ] Tobacco_____________ [ ] Alcohol use ______________________ [ ] Drugs use _________________

II. Current or Past Medical History

Eyes: [ ] crossed eyes [ ] lazy eyes [ ] wears glasses [ ] surgery [ ] other ________________________
Ears: [ ] frequent ear infections [ ] ear tubes [ ] hearing loss [ ] other _____________________________
Nose: [ ] allergy symptoms [ ] frequent nose bleeds [ ] frequent colds [ ] frequent sinus infections
[ ] other ____
Neck/Throat: [ ] frequent strep [ ] enlarged tonsils/adenoids [ ] snoring [ ] other ______________
Mouth/Teeth: [ ] caries [ ] other ____
Chest/Lungs: [ ] chronic cough [ ] wheezing [ ] asthma [ ] shortness of breath [ ] bronchitis
[ ] pneumonia [ ] other ____________________________________
Heart: [ ] heart murmur [ ] chest pain [ ] palpitation [ ] heart defect ________________________________
Digestive Tract: [ ] constipation [ ] recurrent stomachache [ ] frequent diarrhea [ ] recurrent vomiting
[ ] poor appetite [ ] acid reflux [ ] colitis [ ] ______________________________________
Urinary Tract: [ ] bedwetting [ ] infection [ ] stones [ ] reflux [ ] other_____________________________
Muscle/Skeletal: [ ] back pain [ ] knee pain [ ] hip pain [ ] scoliosis [ ] fracture ______________________
[ ] surgery ____
Neuro: [ ] severe headache [ ] migraine [ ] fainting spells [ ] seizure [ ] concussion__________________
Skin: [ ] eczema [ ] acne [ ] mole [ ] birthmarks [ ] other ____
Blood: [ ] easy bruising [ ] blood clots [ ] anemia ______________________ [ ] other_________________
Other: [ ] speech delay [ ] ADD/ADHD [ ] anxiety [ ] sleep disorder [ ] depression [ ] learning disability
[ ] PDD/Autism [ ] behavioral [ ] developmental delay [ ] ________________________________
Serious Injuries/ Hospitalization/Surgery:

Patient's Name: ____ DOB: _______________________

FAMILY HISTORY

Mother's Name:				**Father's Name:**
Occupation:				**Occupation:**
Religion: Ethnicity:				**Religion: Ethnicity**
[ ] Married [ ] Divorce [ ] Single Parent [ ] Other:				
Military Service: [ ] Yes				**[ ] No**
Environment: [ ] Smoke detector [ ] Fluoride [ ] Lead [ ] Tobacco [ ] Pets _________________________				
Patient's Siblings: Name	**Age**	**Sex**	**General Health**	
1				
2.				
3.				

Conditions	**Family Member** (father, mother, siblings, grandparents, aunts, uncles, first cousins)
Diabetes	
High blood pressure	
Stroke	
Cancer	
Heart Disease	
Asthma	
Allergies	
Thyroid disease	
Cystic fibrosis	
Anemia	
Epilepsy/Seizure	
Kidney problem	
Colitis	
Clotting problem	
Birth defects	
Mental retardation	
Mental/Emotional	
Learning Disabilities	
Other	