ELM Pediatrics

New Patient Demographic Form

Child's Name:____Gender: ☐ Male ☐ Female
First Middle Last

Date of Birth:______________________________ Place of Birth:____
(mm/dd/yyyy) (City and State)

Home Address: ____
(Street) (City) (State) (Zip)

Demographic Information

My child's race is: (Please Check One)
☐ American Indian/Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White/Caucasian
☐ Other

My Child's ethnicity is (Please Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

My child's preferred language is: (Please Check One)
☐ English
☐ Spanish
☐ Other: ____________________________________
(Please Provide Preferred Language)

Mother/Guardian's Name: ________________________________ DOB:_______________ SSN: _______________

Occupation: ______________________________________ Employer: _____________________________________

Home #: _________________________ Cell #: _________________________ Other #: _______________________
☐ Preferred ☐ Preferred ☐ Preferred

Email Address: ____

Father/Guardian's Name: _________________________________ DOB:_______________ SSN: _______________

Occupation: ______________________________________ Employer: _____________________________________

Home #: _________________________ Cell #: _________________________ Other #: _______________________
☐ Preferred ☐ Preferred ☐ Preferred

Email Address: ____

Sibling's Names and Dates of Birth:

1. ___________________________ DOB: ____________ 2. ___________________________ DOB: ____________

3. ___________________________ DOB: ____________ 4. ___________________________ DOB: ____________

Primary Insurance:________________________________ Policy Number: _______________ Group #: ___________

Policyholder's Name: ______________________________________DOB: _______________ SSN: _______________

Secondary Insurance: ______________________________ Policy Number: _______________ Group #: ___________

Policyholder's Name: ______________________________________DOB: _______________ SSN: _______________

Child's Birth and Development History

Born at (Name of Hospital): ____ Birth Weight:_______________

Any Problems with pregnancy or delivery: ____

Full term birth? ☐ Yes ☐ No If No, how many weeks at birth? ____

Type of delivery (Please Check One): ☐ Vaginal ☐ C-Section NICU (Please Check One): ☐ Yes ☐ No

Hepatitis B Vaccine Date (if newborn): ____

Any chronic illnesses: ____

Any surgeries: ____

Current Medications: ____

Allergies (medicines, food, environmental): ____

Family History (Please Check Yes or No and explain if indicated)

Allergies/Asthma	☐ Yes	☐ No	If Yes, please explain: ____
Diabetes	☐ Yes	☐ No	If Yes, please explain: ____
Hypertension	☐ Yes	☐ No	If Yes, please explain: ____
Convulsive Disorders	☐ Yes	☐ No	If Yes, please explain: ____
Sickle Cell	☐ Yes	☐ No	If Yes, please explain: ____
Cardiovascular Disease	☐ Yes	☐ No	If Yes, please explain: ____

CONSENT FOR MEDICAL TREATMENT

THIS CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CHILD IS NO LONGER A MINOR

Who may bring the child in for appointments and consent to medical treatment (including vaccines) other than the legal parent/guardian?

Name: ____ Relationship to Patient: _____________________________

Name: ____ Relationship to Patient: _____________________________

Name: ____ Relationship to Patient: _____________________________

Emergency Contact Information

Name: ____ Relationship to Patient: _____________________________

Phone: ____

Name of person filling out this form (printed): ____

Parent/Guardian Signature: ____ Date: _____________________