Eastern Carolina Pediatrics, P.A

1702 Medical Park Dr.
Wilson, NC 27895

Patient Registration

Child 1: *Last Name:* ______________________ *First Name:* __________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* __________________

Ethnicity: Hispanic / Not Hispanic / Unknown *Circle one*
Race: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown *Circle all that apply*

Child 2: *Last Name:* ______________________ *First Name:* __________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* __________________

Ethnicity: Hispanic / Not Hispanic / Unknown *Circle one*
Race: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown *Circle all that apply*

Child 3: *Last Name:* ______________________ *First Name:* __________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* __________________

Ethnicity: Hispanic / Not Hispanic / Unknown *Circle one*
Race: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown *Circle all that apply*

Mailing Address:

____
(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (______) ________ - ___________

Who lives at this household? ____
(Please note, this information is being requested to improve intake of your child's Social History.)

Contact 1: *Name*: ________________________________

Relation to Patient: ______________________ *Biological Relation to Patient:* ______________________

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #*: ____ - ____ - _____

Work Phone: (____) ______ - ___________ *Cell Phone*: (____) ______ - ___________

Home Email: ____ _________________________ *Work Email:* ______________________________

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home Email / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

Contact 2: *Name*: ______________________________

Relation to Patient: _____________________ *Biological Relation to Patient:* _____________________

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) ______ - ___________ *Cell Phone*: (____) ______ - ___________

Home Email: ____ ___________________________ *Work Email:* ________________________________

Employer: _________________________________ *Occupation:* ________________________________

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here:

____

____

Additional Contact Questions:

Who should receive billing statements? ____

May all contacts have access to the patient's records electronically? Yes / No / __________

Insurance:

Primary Policy: *Policy Holder's Name*: ____

Policy Holder's Birth Date: ___________________ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _______________________________ *ID#* ______________________________

Secondary Policy: *Policy Holder's Name*: ____

Policy Holder's Birth Date: ___________________ *Policy Holder's SSN:* _____________

Insurance Carrier: _______________________________ *ID#* ______________________________

If parents are divorced or separated please fill out this section:
Who has custody? ____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

____

Emergency Contacts, <u>other than parents</u>: Name & Relationship (Please list only 3)

1: _____________________________ Relationship _____________________ *Phone*: (___) _____ - _________

2: _____________________________ Relationship _____________________ *Phone*: (___) _____ - _________

3: _____________________________ Relationship _____________________ *Phone*: (___) _____ - _________

DATE: _______________

PATIENTS NAME: _____________________________________ DATE OF BIRTH: _____________________________________

BIRTH HISTORY: IF YES, PLEASE EXPLAIN (ONLY FILL OUT IF YOU ARE A NEW PATIENT OR YOUR CHILD IS <2 YEARS OLD)

Hospital name:		
Age at discharge:		
Illnesses during pregnancy	NO	YES:
Any medications	NO	YES:
Alcohol/Drug use	NO	YES:
Problems at birth/Premature	NO	YES:
Type of Delivery	Vaginal:	C-section:
Birth Weight	Birth:	Discharge:
Feeding:	Breastfeeding	Formula:

PATIENT/FAMILY HISTORY: PLEASE CHECK THE BOXES THAT APPLY TO YOUR CHILD'S HISTORY & SPECIFY

	PATIENT	**MOTHER**	**FATHER**	**SIBLINGS**	**FAMILY**
Blood Disorder (Sickle Cell Disease, Anemia)					
Bone/Joint Disorders (Arthritis, Gout)					
Cancer					
Diabetes					
Eye Problems (Blindness, Lazy Eye, Crossing Eyes)					
Ear Problems (Deafness, Recurrent Ear Infections)					
Gastrointestinal (Ulcer, Crohn's, Celiac)					
Genetic Disorders (Down Syndrome, Cystic Fibrosis)					
Heart Disease (Murmur, Congenital Heart Disease)					
Kidney Disease (Urinary Tract Infection)					
Lung Disorders (Asthma, Wheezing, Tuberculosis)					
Muscle Disorders (Multiple Sclerosis)					
Nervous Disorders (Migraines, Seizures, Epilepsy)					
Psychiatric Disorders (Depression, Bipolar, ADHD, Anxiety)					
Thyroid Problems					
Other (Developmental Delays, Autism, Sickle Cell Trait)					
Sexually Transmitted Diseases (HIV, Herpes, Gonorrhea)					
Alcoholism/Drug Dependency					
Smoker					

MEDICATION NAME	**DOSE**

HOSPITALIZATIONS/SURGERIES	**DATES**