Lake Norman Pediatrics

Chart#

PATIENT INFORMATION

_____ _____ **Sex:** ☐ M ☐ F
Patient Name – First, Middle, Last Name Called

_____
Street Address or PO Box: City State ZIP Code

_____ _____ _____
Date of Birth Patient SS# Home Phone Number

Primary Contact:_____ _____ _____ _____
Name Cell# Work# Home#

****Primary contact will be used for Appointment scheduling, cancellations, lab results, etc.****

Preferred Pharmacy_____ **Location:**_____ **Phone#**_____

CONTACT INFORMATION OR LEGAL GUARDIAN

☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Legal Guardian- Relationship_____

_____ _____
First, Middle Init, Last Date of Birth

_____ _____ _____
SS# Home Phone# Cell #

_____
Street Address or PO Box: City State ZIP Code

_____ _____ _____
Place of Employment: Work Phone # Parent/Guardian E-Mail Address

☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Legal Guardian- Relationship_____

_____ _____
First, Middle Init, Last Date of Birth

_____ _____ _____
SS# Home Phone# Cell #

_____
Street Address or PO Box: City State ZIP Code

_____ _____ _____
Place of Employment: Work Phone # Parent/Guardian E-Mail Address

INSURANCE INFORMATION

_____ _____ _____
Primary Insurance Company Policy Holders Name SS#

We file all Primary Insurances
We file Secondary insurance only with BC/BS, Tricare and Medicaid
Copy of insurance cards are required to file insurance / <u>Copay</u> is required at time of service

_____ _____
Signature of Parent/Legal Guardian Date

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Chart#

PATIENT HISTORY FORM

_____ _____ **Sex:** ☐ M ☐ F

Patients Name – First Middle Last Date of Birth

Allergies:

Drug _____Reaction_____

Food_____Reaction_____

Environmental Allergies_____ Reaction_____

☐ No Known Allergies – Date _____

Does anyone smoke in the household? ☐ Yes ☐ Outside Only ☐ No

OTHER CHILDREN IN FAMILY

Name:_____ Name:_____ Name:_____

Name:_____ Name:_____ Name:_____

PLEASE CHECK – PATIENT HISTORY

☐ Anemia	☐ Delayed Development	☐ Heart Condition	☐ Strep Throat
☐ Asthma	☐ Diabetes	☐ Kidney Problems	☐ Tonsillitis
☐ Cancer	☐ Ear Infections	☐ Leukemia	☐ Wheezing
☐ Chicken Pox	☐ Feeding Problems	☐ Prematurity	☐ Other _____
	☐ Hearing Impairment	☐ Speech Impairment	

List Surgeries/Hospitalizations:_____

IMMUNIZATIONS- A copy of your child's immunization record is required

PLEASE CHECK – FAMILY HISTORY /RELATIONSHIP TO PATIENT

☐ Allergies _____	☐ Diabetes_____	☐ Kidney Problems _____
☐ Anemia _____	☐ Heart Condition_____	☐ Lung Problems _____
☐ Asthma _____	☐ High Blood Pressure_____	☐ Other _____
☐ Cancer _____	☐ High Cholesterol_____	

BIRTH HISTORY

Location: _____ Pediatrician:_____

Birth Weight:_____Length_____ ☐ Breastfed ☐ Formula _____Oxygen Required ☐ Yes

Complications:_____

SOCIAL HISTORY

Parent Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated

Who has legal custody of child? ☐ Mom ☐ Dad ☐ Grandparents ☐ Other _____

Who will bring child to the office? (Check all that apply) ☐ Mom ☐ Dad ☐ Grandparents ☐ Stepmom

☐ Stepfather ☐ Other _____