PATIENT REGISTRATION FORM

To be completed by parent

Heart to Heart Pediatrics LLC

Date: _____

CHILD'S INFORMATION

First Name:	Middle Initial:	Last Name:
Date of Birth:	Gender: ☐ Male ☐ Female	Race:
Ethnicity: ☐ Hispanic ☐ Non-Hispanic		

FAMILY INFORMATION

PRIMARY CONTACT	SECONDARY CONTACT
Parent's Name: Relationship:	Parent's Name: Relationship:
Date of Birth:	Date of Birth:
Street Address:	Street Address: ☐ Same as Primary
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Ok to text? ☐ Yes ☐ No Please initial:	Ok to text? ☐ Yes ☐ No Please initial:
Email:	Email:
Ok to email? ☐ Yes ☐ No Please initial:	Ok to email? ☐ Yes ☐ No Please initial:
Occupation:	Occupation:
Employer:	Employer:

Please list all those living in the home:

If parents not married, please explain custody status:

Stepparent(s) Name: ☐ N/A

Name: Name:

EMERGENCY CONTACT INFORMATION

Emergency Contact (Other than parent):	
Phone:	Relationship to Patient:

INSURANCE INFORMATION

PRIMARY INSURANCE (Please provide card)

Name of Insurance:	Policy #:	Group #:
Policy Holder:		

SECONDARY INSURANCE (Please provide card) ☐ N/A

Name of Insurance:	Policy #:	Group #:
Policy Holder:		

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Heart to Heart Pediatrics, LLC to release any information acquired in the course of my child's examinations or treatments to my insurance company.

Parent/Guardian's Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

To be completed by parent

Heart to Heart Pediatrics LLC

Date: _____

Patient Name:	Date of Birth:
Is the patient adopted? ☐ Yes ☐ No	
Current prescribed medications:	
Current vitamins/supplements:	
Allergies (include reaction)	
Medications:	
Food:	
Is your child vaccinated on the routine AAP schedule? ☐ Yes ☐ No	If not, please explain:
Any previous reactions to vaccines?	

Medical History:

- ☐ Seasonal Allergies
- ☐ Eczema
- ☐ Headaches
- ☐ Problems with vision
- ☐ Problem with hearing
- ☐ Recurrent Ear Infections
- ☐ Recurrent Strep Throat
- ☐ Asthma
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ GERD
- ☐ Constipation
- ☐ Chronic Diarrhea
- ☐ Bladder/Kidney Disease
- ☐ Recurrent UTIs
- ☐ Bedwetting (after age 5)
- ☐ Thyroid Disorder
- ☐ Diabetes (Type 1/Type 2)
- ☐ Developmental Delay
- ☐ Autism
- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Prematurity _____ weeks

Other Medical History:
Hospitalizations:
Surgeries:
Current Specialists:

FOR CHILDREN UNDER 1 YEAR OLD

Birth History:	☐ Term (>37 weeks)	☐ Born Premature @ weeks	☐ Single	☐ Multiple Births
Mother's age at child's birth:	Father's age at child's birth:	Birth Weight:	Birth Length:	
Complications:				

Growth & Development:	Has growth occurred at a normal rate? ☐ Yes ☐ No
Describe any current developmental issues:	
Any current therapy services?	
For females, age of start of menstrual cycle:	

FAMILY MEDICAL HISTORY

Date: _____

Heart to Heart Pediatrics LLC

PATIENT'S INFORMATION		
First Name:	Middle Initial:	Last Name:
Date of Birth:		

FAMILY MEDICAL HISTORY			
Does the below history apply to any other children? If so, please list their names and DOB and we'll apply to their charts as well.			
Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

Please put a check in the box if child's natural parents, siblings, aunts, uncles, or grandparents have had any of the following. Also, please indicate which family member has/had that condition (MGM-Maternal Grandmother, etc).

- ☐ Seasonal Allergies _____
- ☐ Food Allergies _____
- ☐ Eczema _____
- ☐ Asthma _____
- ☐ Headaches _____
- ☐ Epilepsy/Seizures _____
- ☐ Developmental Delay _____
- ☐ Autism Spectrum Disorder _____
- ☐ Hyperactivity/ADHD _____
- ☐ Anxiety/Depression _____
- ☐ Other mental health history _____
- ☐ Sight/Hearing Problems _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ High Triglycerides _____
- ☐ Heart Attack/Stroke before age 55 _____
- ☐ Sudden Death (cardiac, etc.) _____
- ☐ Crohns _____
- ☐ Ulcerative Colitis _____
- ☐ Celiac Disease _____
- ☐ Irritable Bowel Disease _____
- ☐ Other Gastrointestinal Disease _____
- ☐ Liver Disease _____
- ☐ Kidney Disease _____
- ☐ Thyroid Disease _____
- ☐ Diabetes _____
  - ☐ Type 1 (Juvenile) _____
  - ☐ Type 2 (Adult-Onset) _____
- ☐ Cancer _____
- ☐ Blood Disorders _____
- ☐ Blood Clotting Disorders _____
- ☐ Genetic Disorders _____
  - ☐ MTHFR _____

ADDITIONAL FAMILY HISTORY	
☐ None of the Above	☐ Family History Not Known