SOUTHSIDE PEDIATRICS, INC.

PATIENT INFORMATION

DATE _____ SSP ACT.#_____

(PLEASE PRINT ALL INFORMATION)

PATIENT NAME _____ DATE OF BIRTH _____
Last First M.

ADDRESS_____
Street - Apt. # - Lot #

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE #_(____)_____ PATIENT SEX M__ F__ AGE_____SS#_____

MOTHER'S NAME_____ DOB _____ SS#_____

ADDRESS _____ HOME PHONE #_(____)_____

EMPLOYER _____ CELL PHONE # (____)_____
Name Address
BUSINESS PHONE #_(____)_____

FATHER'S NAME_____ DOB _____ SS#_____

ADDRESS _____ HOME PHONE #_(____)_____

EMPLOYER _____ CELL PHONE # (____)_____
Name Address
BUSINESS PHONE #_(____)_____

OTHER RELATIVE OR FRIEND IN CASE OF EMERGENCY_____

ADDRESS_____TELE # (____)_____

RACE
CAUCASIAN (WHITE) _____
BLACK/AFRICAN AMERICAN _____
ASIAN _____
AMERICAN INDIAN _____
OTHER RACE _____

ETHNICITY
LATINO/HISPANIC _____
OTHER _____
PREFER NOT TO ANSWER _____

OTHER CHILDREN IN FAMILY:

Last Name	*First Name*	*MI*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REFERRED BY: _____

(OVER)

Insurance Information

Primary Insurance:_____
Name Address

Policy Holder's Name:_____DOB:_____Relationship to Patient:_____

Insurance ID:_____Group #:_____

Policy Holder's Employer:_____

Secondary Insurance:_____
Name Address

Policy Holder's Name:_____DOB:_____Relationship to Patient:_____

Insurance ID:_____Group #:_____

Policy Holder's Employer:_____

Patient's Authorization to Release Medical Information & Claim Payment

I hereby authorize the above physician(s) to release any information regarding services rendered by him/her and allow a photocopy off my signature to be used to file my insurance.

I also direct my insurer to issue payment check(s) for benefits due to me for the services rendered by the above named physician(s) to be made directly to him. Regardless of my insurance benefits, if any. I understand I am financially responsible for the fees for services rendered unto me.

_____ _____
(Date) Patient (Parent/Guardian) Signature

PATIENT NAME _____ **DOB** _____

MEDICAL HISTORY

Please check ☑ if child has ever had any of the following:

❑ Allergies to Medicine

_____

_____

❑ Allergies- Environmental

_____

❑ Anemia
❑ Asthma
❑ Bronchitis
❑ Chicken Pox
❑ Hepatitis
❑ Measles (10-day)
❑ Measles, Rubella (3-day)
❑ Mumps
❑ Rheumatic Fever
❑ Pneumonia
❑ Whopping Cough

GENERAL

❑ Dizziness
❑ Epilepsy
❑ Fainting
❑ Headache
❑ Numbness
❑ Sweating
❑ Tiredness
❑ Weight Loss/Gain

CARDIOVASCULAR

❑ Breathing Problems
❑ Chest Pain
❑ High Blood Pressure
❑ Irregular Heart Beat

EYES

❑ Crossed or Wandering Eyes
❑ Eye Irritation
❑ Headaches
❑ Vision Problems

HEARING/SPEECH

❑ Difficulty Hearing
❑ Earache
❑ Ear Infections
❑ Hoarseness
❑ Speech Problems

_____

DENTAL

❑ Bleeding Gums
❑ Sensitivity to Hot/Cold
❑ Thumb-Sucking
❑ Last Dental Check-Up

Date _____

GASTROINTESTINAL

❑ Appetite Poor
❑ Bloody or Dark Stools
❑ Constipation
❑ Diarrhea
❑ Excessive Thirst
❑ Nausea
❑ Rectal Bleeding
❑ Stomachaches
❑ Vomiting
❑ Worms

GENITO-URINARY

❑ Bed-Wetting
❑ Blood in Urine
❑ Diaper Rash, Persistent
❑ Frequent Urination
❑ Painful Urination

MUSCLE/JOINT/BONE

❑ Broken Bones or Sprains
❑ Coordination Problems
❑ Posture Problems

Pain, Weakness, Swelling in:

❑ Arms ❑ Hands
❑ Feet ❑ Legs

NOSE/THROAT/CHEST

❑ Frequent Colds
❑ Hoarseness
❑ Mouth-Breathing
❑ Nosebleeds
❑ Persistent Cough
❑ Sinus Problems
❑ Sore Throats
❑ Strep Throat
❑ Wheezing

SKIN

❑ Bruise Easily
❑ Change in Moles
❑ Hives
❑ Itching
❑ Rash
❑ Sores that wont Heal

FAMILY HISTORY OF:

❑ Allergies ❑ Asthma ❑ Diabetes
❑ Epilepsy ❑ High Blood Pressure ❑ Smokers in the Home

ANY OTHER PERTINENT FAMILY MEDICAL HISTORY: _____