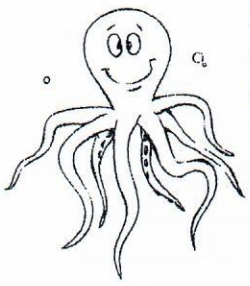
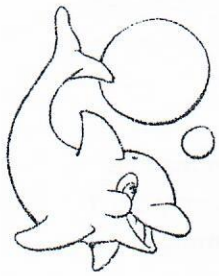


Patient and Family History

Child's Name _____ Birthdate _____ ☐ Male ☐ Female
Social Security # _____ Home Phone _____
Home Address _____ Cell Phone _____
City _____ State _____ Zip _____
School _____ Grade _____
Child Lives with _____ Relationship to Child _____
Sibling Names _____
Whom may we thank for referring you to our office? _____
Preferred Pharmacy? _____



Name of Mother/Guardian _____ Birthdate _____
Social Security # _____ Home Phone _____
Home Address _____ Cell Phone _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Occupation _____
Email _____

Name of Father/Guardian _____ Birthdate _____
Social Security # _____ Home Phone _____
Home Address _____ Cell Phone _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Occupation _____
Email _____

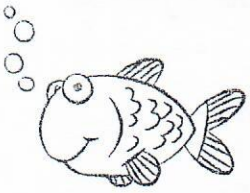
Child's Health History

Former Doctor _____ Office Phone _____
Address _____
City _____ State _____ Zip _____
Date of last doctor visit _____
Child's Height _____ Weight _____ Weight at Birth _____
Does your child take vitamins, fluoride, iron, or other supplements? ☐ Yes ☐ No
Please list any medications your child is currently taking: _____

Please check all that apply to your child:

☐ Allergies
☐ Anemia
☐ Asthma
☐ Bed Wetting
☐ Cancer
☐ Chicken Pox
☐ Congenital Heart Defect
☐ Convulsions/Epilepsy
☐ Croup
☐ Dental Problems
☐ Developmental Problems
☐ Diabetes
☐ Diarrhea or Constipation
☐ Discipline Problems
☐ Ear Infections
☐ Eating Problems
☐ Eczema/Skin Problems
☐ Emotional Problems
☐ Epilepsy
☐ Eye Problems
☐ Epilepsy
☐ Eye Problems
☐ HIV/AIDS
☐ Handicaps/Disabilities
☐ Hearing Problems
☐ Heard Murmur
☐ Hemophilia
☐ Hepatitis – Type ____
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney/Bladder Problems
☐ Mumps, Measles
☐ Pneumonia
☐ Rheumatic Fever
☐ Sleeping Problems
☐ Speech Problems
☐ TB/Lung Disease
☐ Temper Problems
☐ Thumb Sucking
☐ Toilet Training Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Other

Please describe any special medical conditions _____



Primary Health Insurance

Person responsible for account _____

Relationship to patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Home Address _____ Cell Phone _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

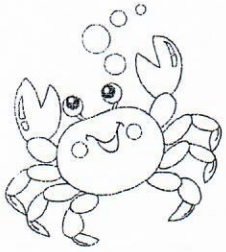
Business Address _____ Occupation _____

Primary Insurance Company _____

Insurance Company Address _____

Subscriber Name _____ Date of Birth _____

Subscriber ID # _____ Group # _____



Disclosure of Information

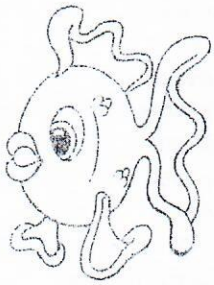
I authorize disclosure of information regarding my child's care. Please authorize who may be allowed to pick up prescriptions, contact our office for an appointment, or accompany my child to an office visit if I am unavailable. I will allow information to be released to the following people:

Name	Date of Birth	Relationship to Patient	Phone Number

Assignment and Release

I hereby authorize payment directly to ANCIENT CITY PEDIATRICS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or by my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.



Signature of Responsible Party _____

Date _____