PATIENT REGISTRATION FORM
ENDOCRINE KIDS

Rev 05/27/14

(Please print clearly in ink)

PATIENT **INFORMATION** Date: _____

Name: _____ Social Security No. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Birthdate: _____ Age: _____ Sex: _____

Primary physician: _____ Referred by: _____

Referring physician phone: (____) _____ Referring physician fax: (____) _____

Pharmacy: _____ Street/City: _____ Phone: (____) _____

How did you hear about us? (please circle) Physician referral Friend/Family Search Engine Facebook

FOR A MINOR

Mother's name: _____ Social Security No. _____ Birthdate: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Occupation: _____ Employer: _____

Father's name: _____ Social Security No. _____ Birthdate: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Occupation: _____ Employer: _____

Preferred primary Email*: _____

***** Your email will only be used for communication with our office and appointment reminders. We will not sell or disclose your email to third parties without your prior consent. If no e-mail address is given, Dr. Bishop will not be able to respond to any e-mail you send via our secure system.

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Claims Address: _____

Policy Holder Name: _____ Birthdate: _____ Social Security No. _____

Contract#: _____ Group#: _____

Secondary Insurance Co. _____ Claims Address: _____

Policy Holder Name: _____ Birthdate: _____ Social Security No. _____

Contract#: _____ Group#: _____

OFFICE DISCLOSURE

The following non-parent individual(s) are permitted to bring my child to the Endocrine Kids office for evaluation/treatment and obtain confidential health information on my child, if necessary.

Name: _____ Relationship to patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Name: _____ Relationship to patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Date: _____/_____/_____

Signature_____

ENDOCRINE KIDS PATIENT HISTORY FORM

Patient's name _____

PAST MEDICAL HISTORY:

Birth weight: _____ Birth length: _____

Ongoing / major medical or psychological conditions:

_____

_____

_____

Medications:

_____

_____

Medication allergies: yes no If yes, to what medication(s)? _____

Surgeries:

_____

_____

REVIEW OF SYSTEMS:

Does your child have, or has he/she recently had, any of the following: (Please circle)

CONSTITUTIONAL: weight loss, fever, chills, weakness, fatigue
EYES: visual loss, blurred vision, double vision
EARS, NOSE, THROAT: hearing loss, congestion, runny nose, sore throat, difficulty swallowing
SKIN: rash, itching
CARDIOVASCULAR: chest pain, rapid heart rate, limb swelling
RESPIRATORY: shortness of breath, recurring cough
GASTROINTESTINAL: nausea, vomiting, diarrhea, frequent abdominal pain
GENITOURINARY: Burning on urination, frequent urination, increased thirst
NEUROLOGICAL: frequent headache, dizziness, episodes of fainting, numbness or tingling in the extremities, change in bowel or bladder control.
MUSCULOSKELETAL: frequent muscle pain, joint pain
HEMATOLOGIC: increased bleeding, increased bruising
PSYCHIATRIC: recurring depression, recurring anxiety

SOCIAL HISTORY:

Are child's parents □ married □ single □ separated □ divorced

Parents' occupations:
Mother _____

Father _____

Who lives in the home? (List by relationship to patient - example: mother, father, sister and brother)

_____

_____

Child's current education (please circle one):

Daycare Preschool Public/private school Home-school College

Current (or upcoming) grade: _____

Child's hobbies:

_____

_____

FAMILY HISTORY:

Is this child yours by: □ birth □ adoption □ stepchild □ other _____

Family Member (i.e. father, aunt, maternal grandmother (MGM), etc…)

- □ Alcoholism/drug abuse _____
- □ Anxiety _____
- □ Depression _____
- □ Diabetes, Type 2 _____
- □ Cancer, please specify _____
- □ Heart attack before age 55 _____
- □ High blood pressure _____
- □ Migraines _____
- □ High cholesterol _____
- □ Obesity _____

□ Autoimmune disease (such as type 1 diabetes, thyroid disease, rheumatoid arthritis, Crohn's disease, lupus, multiple sclerosis etc…)
Please specify disease type and family member affected: