STERLING HEALTH CARE - CHILD

To speed up the check in process, please fill in ALL information

Please check the site where you are wanting to be seen:

□Sterling Women's Health □Sterling Healthcare □Bath Family Health Services

GUARDIANSHIP INFORMATION

Are you the child's legal guardian? □Yes □No

If you marked no, who has legal guardianship? ____

****If you are not the biological or adoptive parent, you must provide legal documentation of guardianship****

DEMOGRAPHIC INFORMATION

Last Name: ______________________**First Name**:______________________**Middle Name:** ____________________

Gender: M/F **SSN:**______________________**Birth Date:**______________________**Nickname:**________________

Race: □American Indian/Alaskan Native □Asian □Black/African American □Native Hawaiian □White □ Other

Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino

Address:____ **Zip Code**:_______________________

Home Phone: ____________________ **Cell Phone:** __________________**Work Phone:** _______________________

Email Address: ____**Preferred Communication**: Phone/Email

Preferred Phone Contact: □Home □Cell □Work **Preferred Language:** □English □Spanish □Interpreter Needed
Living Situation □ Homeless □Transitional □Doubling Up □Street □Other □Unknown □Not Homeless
Agricultural Worker □ Migrant □Seasonal **Are you a Veteran** □Yes □No

Who is/was your last Primary Care Provider? ____

Reason for Transfer of Care ____

In case of Emergency, please contact:

Name_________________________________ **Phone:** _______________________________**Relation:**___________

Address____

Pharmacy: ___________________________________

INSURANCE INFORMATION:

Primary Insurance: _____________________________ **ID#**______________________ **GROUP#**_________________
Secondary Insurance: ___________________________**ID#**______________________ **GROUP#**_________________
Subscriber Name:____________________________________**Subscriber Date of Birth**_________________________
Subscriber Gender: □Female □Male **Subscriber Phone**______________________________
Subscriber Address if different from Patient:____

GUARANTOR INFORMATION

Employment Information:

□Full-time □Part-time □Unemployed □Full-time Student □Part-time Student
□Retired □Unknown □Active Military Duty

Employer Name: ____ **Employer Phone**:____________________

Employer Address: ____

CHILD NEW PATIENT HISTORY

How were you referred to our practice? ____

Current problems/Concerns ____

____

ALLERGIES

Medications	
Vaccines	
Food	
Other	

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

BIRTH HISTORY

Was this child? ☐Full term ☐Pre-term ☐Adopted

If pre-term, how many weeks? ____________ If adopted, at what age? ___________

Type of delivery? ☐Vaginal ☐ C-section If C-section, why? ____

Birth weight ____________________ Breech? ☐Yes ☐No

Any problems during the newborn period? ☐Yes ☐No

If yes, please explain____

____

CHILD'S PAST MEDICAL HISTORY

Any Hospitalizations? ☐Yes ☐No

Reason for Hospitalization	Date of Hospitalization	Facility Where Hospitalized

Any Surgeries? ☐Yes ☐No

Type of Surgery	Date of Procedure	Facility Where Procedure Was Performed

Any recent Emergency room or urgent care visits? ☐Yes ☐No
If yes, please explain ____

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

Condition	Y	N	Condition	Y	N
Allergies			Ear Infections		
Asthma			Chicken Pox		
Eczema			Urinary Tract Infection		
Seizures			Acne		
Heart Murmur			Serious Injury or Concussion		
Wheezing			Developmental and/or Speech Problems		
Pneumonia			ADHD/ADD		

For girls only, has she started her menstrual cycle? ☐Yes ☐No If so, at what age ________________

Other history of chronic problem? ____

Has your child ever been seen by a specialist? ☐Yes ☐No
If so, please describe? ____

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)	**Condition**	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)
Heart Attack	Age:	Colitis	
High Blood Pressure		Crohn's Disease	
Congestive Heart Failure		Colon Polyps	
Rheumatic Heart Disease		Hepatitis	
Congenital Heart Disease		Stomach Ulcer	
Breast Cancer	Age:	Kidney Disease	
Colon Cancer	Age:	Stroke	

Leukemia		Migraine	
Melanoma (skin cancer)		Seizures	
Ovarian Cancer		Diabetes	
Pancreatic Cancer		Goiter	
Any other Cancer		Bleeding Tendency	
Asthma		Suicide	
Tuberculosis		Mental Illness	
Other		Drug or Alcohol Abuse	

SOCIAL HISTORY

Who lives in your child's home? ____

____

Is your child in: ☐Daycare ☐School If so, what grade? ____________

Does anyone in the house smoke? ☐Yes ☐No

Do you have any concerns about your child's school performance? ☐Yes ☐No

If yes, please explain ____

____

Do you have any special concerns about your child? ☐Yes ☐No

If yes, please explain ____

____

Is there anything more you would like us to know about your child? ☐Yes ☐No

If yes, please explain ____

____

Form completed by: ___________________________________ Relationship to child_________________________

**** You must bring current insurance cards, photo ID, to the first appointment.****

*****Immunization records must be submitted with the new patient packet.*****