Advanced Medical Center

Pediatric Gastroenterology

NEW PATIENT PACKET

Patient First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph#: _____ Cell Ph#: _____

Which is the best phone number to reach you at: Home ph# _____ Cell ph#: _____

DOB: _____ Sex (M/F):_____

**** About the Mother****

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph#: _____ Cell Ph#: _____

Employer: _____ Work Ph#: _____

****About the Father****

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph#: _____ Cell Ph#: _____

Employer: _____ Work Ph#: _____

Insurance Information

Primary Insurance Company: _____ Policy Holders Name: _____

SSN#: _____ DOB: _____ PH#: _____

Policy ID#: _____ Group#: _____

Policy Holder Employer: _____

Secondary Insurance Company: _____ Policy Holders Name: _____

SSN#: _____ DOB: _____ PH#: _____

Policy ID#: _____ Group#: _____

Policy Holder Employer: _____

Please describe the MAIN reason for your child's visit:

_____

_____

Referring Physician Information

Patient Name: _____ DOB: _____

First Name: _____ Last Name: _____

Physicians Address: _____ Ph# _____ FX: _____

If Referring Physician is different from PCP, please fill out the following:

PCP First Name: _____ Last Name: _____

Address: _____Ph#_____Fx: _____

Preferred Pharmacy Information

Pharmacy Name: _____ Cross Streets: _____

City: _____ Phone#: _____

Drug Allergies

Medication Name: Reaction type: (i.e., rash, hives, difficulty breathing etc.)

_____ _____

_____ _____

_____ _____

Food Allergies & Reaction(s)

_____ _____

_____ _____

Infant/Baby Formula: List any negative reactions he/she has had from the formula

_____ _____

_____ _____

Surgeries & Hospitalizations:

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____

Please list any medications that are currently active: **Amount and times per day:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

PAST MEDICAL HISTORY FOR THE PATIENT (CIRCLE YES/NO WHEN INDICATED)

Patient Name: _____ DOB: _____

Birth Weight: _____ Premature: YES / NO If yes, how many weeks premature? _____

If patient is an infant, did he/she pass stool (meconium) after birth? YES/ NO

If patient is an infant, did he/she have prolonged jaundice after birth? YES / NO

PLEASE MARK YES/NO IF THE PATIENT HAS ANY OF THE FOLLOWING INDICATIONS/ DIAGNOSIS

GENERAL

	YES	NO
Weight Loss	____	____
Fever	____	____
Fatigue	____	____
Bruising/Bleeding	____	____

Head and Neck

Eye Changes	_____	_____
Wear Glasses	_____	_____
Nasal Congestion	_____	_____
Sinus Infection	_____	_____
Frequent Cold	_____	_____
Tooth Decay	_____	_____
Mouth Sores	_____	_____

SKIN

Rashes	_____	_____
Itching	_____	_____

Neurologic

Headaches	_____	_____
Seizures	_____	_____

Psychiatric

Anxiety	_____	_____
Depression	_____	_____
Mood Changes	_____	_____

CARDIAC

	YES	NO
Murmur	____	____
High Blood Pressure	____	____
Fainting	____	____
Heart Rhythm Changes	____	____

GI

Abdominal Pain	_____	_____
Diarrhea	_____	_____
Constipation	_____	_____
Jaundice	_____	_____
Vomiting	_____	_____
Heartburn/Reflux	_____	_____
Appetite Loss	_____	_____
Swallowing Problems	_____	_____

GENITOURINARY

Difficult Urination	_____	_____
Blood in Urine	_____	_____
Urinary Tract Infection	_____	_____
Bed Wetting	_____	_____
Abnormal Menstrual	_____	_____

Muscle/Joints

Joint Redness	_____	_____
Joint Swelling	_____	_____
Muscle Aches	_____	_____

OTHER: _____

Patient Name: _____ DOB: _____

Use the following symbols: M=Mother, F=Father, S=Sister, B=Brother, MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGM= Paternal Grandmother, MU= Maternal Uncle, MA=Maternal Aunt, PU= Paternal Uncle, PA= Paternal Aunt, O=Other (i.e. cousin)

PLEASE MARK BELOW WITH ANY OF THE ABOVE SYMBOLS IF ANY FAMILY MEMBER HAS DISORDER LISTED BELOW.

_____ GERD(Reflux Disease)
_____ Irritable Bowel Syndrome
_____Food Allergies
_____ Gallstones/Cirrhosis
_____ High Cholesterol
_____ Seizures
_____ Anxiety
_____ Migraines
_____ Ulcerative Colitis
_____ Bleeding Disorders
_____ Colon Polys
_____Stomach Ulcers
_____Crohn's Disease
_____Lactose Intolerance
_____Constipation
_____ Child / Infant Death

OTHER FAMILY DISORDERS WE SHOULD KNOW OF:
_____

SOCIAL HISTORY FOR THE PATIENT

Please list all members living in the household (EX. Mother, Father, Sister etc.)

_____
_____

Is your child in school / preschool/ daycare? **YES / NO** **IF YES,** what grade? _____

Have there been any missed school days because of symptoms? **YES / NO**

Please list any family, social, or school stressors: _____

_____

_____

Please list patient's favorite activities, sports, or extra-curricular activities: _____

_____

Has there been any recent travel outside of the U.S? **YES / NO**

IF YES, where? _____ **How long ago?**_____

Patient Name: _____ DOB: _____

RELEASE OF MEDICAL INFORMATION

I give my permission to release confidential health information to the following people: _____

These people can also bring patient to appointments

Name: _____Relationship_____ DOB_____

Name: _____Relationship_____ DOB_____

Name: _____Relationship_____ DOB_____

**** Please specify if there is any personal health information you DO NOT want to be disclosed to the above-named people.**

TELEPHONE CONTACT

Primary Number (including area code) _____

Can we call you at this number? **YES / NO**

Can we leave a message on your voicemail to return our call? **YES / NO**

Can we leave a message on your voicemail stating negative lab results? **YES / NO**

Can we leave a message with the person answering the phone to return our call? **YES / NO**

Secondary Number (including area code) _____

Can we call you at this number? **YES / NO**

Can we leave a message on your voicemail to return our call? **YES / NO**

Can we leave a message on your voicemail stating negative lab results? **YES / NO**

Can we leave a message with the person answering the phone to return our call? **YES / NO**

Print Patient Name: _____ DOB:_____

Print Parent/Guardian Name: _____ DOB:_____

Parent Signature: _____ Date: _____

**** It is your responsibility to notify the office in writing of your request to change or update any of the above information****