Hendricks
Regional Health

Hendricks Regional Health Medical Group
Pediatric Patient Registration

Please Print Clearly

Date_____

Patient Information

Name _____

Address _____

City _____

State _____ Zip Code_____

Home Phone_____

Parent Phone Number (cell)_____

Parent Phone Number (work)_____

Date of Birth _____ Male ☐ Female ☐

Single ☐ Married ☐ SSN_____

Emergency Contact _____

(**NOT** living with you)
Emergency Contact phone _____

Relationship to Emergency Contact _____

Primary Insurance _____

Secondary Insurance_____

Local Pharmacy _____
(name and location)

Mail In Pharmacy _____

Referred By _____

Email address _____

Physician _____

Responsible Party (person who will receive statements)

Name_____

Address _____

City _____

State _____ Zip Code _____

Parent Information

Mother's Name_____

Address _____
(If different from patient)

Father's Name _____

Address _____
(If different from patient)

Custodial Parent if Divorced _____

Insured Information

Primary Ins: Insured Name _____
Date of Birth _____ SSN _____
Relationship to patient _____

Secondary Ins: Insured Name _____
Date of Birth _____ SSN _____
Relationship to patient _____

Additional Information

Race _____

Ethnicity _____
(Options: Hispanic, Non-Hispanic, Refuse to report)

Primary Language _____

PLEASE FILL OUT THESE FORMS COMPLETELY AND ACCURATELY. FAILURE TO DO SO MAY RESULT IN A COMPROMISE IN OUR ABILITY TO DELIVER APPROPRIATE CARE.

History of Presenting Illness

Why are you being seen today? _____

How long have you had this problem? _____

Please list the tests/treatments you have had done related to this problem:

_____

Who is your primary doctor? _____ **Who referred you here?** _____

Current Medications: List dosing and frequency taken. Please provide separate list if not enough spaces.

1 _____

2 _____

3 _____

4 _____

5 _____

Allergies: Please list any medication, food, or environmental allergies that you have. Include the reaction (ie: rash, nausea, etc.).

_____

_____

Past Medical and Surgical History: Please list all procedures that you have had (include surgeries, endoscopies, heart procedures, etc.).

_____

_____

_____

Family History: Please list any relevant medical conditions in the family and relationship to patient.

_____

_____

Social History:

Marital status _____ **Occupation** _____
Tobacco use-have you ever smoked/chewed? _____ **Do you use currently?** _____ **Packs per day?** _____
Alcohol use: _____ **How often?** _____
Caffeine intake (how much per day): _____ **Carbonated beverage intake:** _____
Any pets in the home? _____ **If so, list:** _____
Age of home? _____

Review of Systems

Mark the following symptoms or conditions that apply to you

General
- ◯ Activity change
- ◯ Appetite change
- ◯ Chills
- ◯ Sweats
- ◯ Fatigue
- ◯ Fever
- ◯ Weight change

Ears, Nose, Throat
- ◯ Congestion
- ◯ Dental problem
- ◯ Drooling
- ◯ Ear discharge
- ◯ Ear pain
- ◯ Facial swelling
- ◯ Hearing loss
- ◯ Mouth sores
- ◯ Nosebleeds
- ◯ Postnasal drip
- ◯ Runny nose
- ◯ Sinus pain
- ◯ Sinus pressure
- ◯ Sneezing
- ◯ Sore throat
- ◯ Ringing in ears
- ◯ Trouble swallowing
- ◯ Voice change

Respiratory
- ◯ Stop breathing
- ◯ Chest tightness
- ◯ Choking
- ◯ Cough
- ◯ Shortness of breath
- ◯ Stridor
- ◯ Wheezing

Cardiovascular
- ◯ Chest pain
- ◯ Leg swelling
- ◯ Palpitations

Gastrointestinal
- ◯ Abdominal swelling
- ◯ Abdominal pain
- ◯ Anal bleeding
- ◯ Blood in stool
- ◯ Constipation
- ◯ Diarrhea
- ◯ Nausea
- ◯ Rectal pain
- ◯ Vomiting

Endocrine
- ◯ Cold intolerance
- ◯ Heat intolerance
- ◯ Excessive thirst
- ◯ Excessive hunger
- ◯ Excessive urination

Musculoskeletal
- ◯ Joint pains
- ◯ Back pain
- ◯ Trouble walking
- ◯ Joint swelling
- ◯ Muscle pains
- ◯ Neck pain
- ◯ Neck stiffness

Allergy / Immune system
- ◯ Allergies to pollen, mold, or pet
- ◯ Food allergies
- ◯ Weakened immune system

Neurological
- ◯ Dizziness
- ◯ Facial weakness
- ◯ Headaches
- ◯ Lightheadedness
- ◯ Numbness
- ◯ Seizures
- ◯ Speech difficulty
- ◯ Passing out
- ◯ Tremor / shakes
- ◯ Weakness

Hematological
- ◯ Large lymph node
- ◯ Bruise/bleed easily

Hendricks
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At Hendricks Regional Health we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us who we can speak to regarding your health information. You are not required to list anyone and you can change who we are permitted speak to at any time by completing a new form.

I authorize Hendricks Regional Health Medical Group physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

	Name	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

_____ _____
Signature **Date**

_____
Witness

Patient Printed Name _____ Date of Birth _____