UPPER ARLINGTON PEDIATRICS

An Affiliate of Nationwide Children's Hospital

Patient Information Form: Please Print

Please fully complete

Patient Information:

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ ZIP _____

DOB _____ Sex: ☐ Male ☐ Female Phone#_____

Parent or Legal Guardian Information:

First Name _____ Last Name _____ DOB _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail _____ SSN _____ Relationship to Patient _____

Employer _____

Child lives with ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Legal Guardian ☐ Other

Parent or Legal Guardian Information:

First Name _____ Last Name _____ DOB _____

Address _____ City _____ State _____ZIP_____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail _____ SSN _____ Relationship to Patient _____

Employer _____

Primary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk

Insurance Name _____ Address _____

Policy Holder _____ DOB _____ Employer _____

ID# _____ Group# _____ SS# (If needed for billing) _____

Secondary Insurance: Is this an affordable care marketplace plan? Y N If yes, please stop and see the front desk

Insurance Name _____ Address _____

Policy Holder _____ DOB _____ Employer _____

ID# _____ Group# _____ SS# (If needed for billing) _____

Please list all children in your family who come to this practice:

_____DOB _____ _____DOB _____ _____DOB _____

_____DOB _____ _____DOB _____ _____DOB _____

Preferred E-Mail for the patient portal: _____

Preferred Pharmacy: _____ Address _____ Phone _____

Emergency Contact:

Name _____ Relationship _____ Phone _____

How were you referred to this practice?

Existing patient _____ Physician _____ Name of patient or physician _____

Newspaper _____ Telephone _____ Internet _____ Website _____ Insurance company _____

Other _____

I authorize the providers of the practice to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to the practice. If my insurance company rejects or allows only part of the claim for services, I shall be responsible for payment of the balance due and will pay the balance within thirty (30) days.

Printed name of patient or parent/guardian Signature Date

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Patient Name_____Birth Date_____

Past Medical History

Has our child ever been treated or diagnosed with: (explain)

	Yes	No
Asthma/wheezing/pneumonia	□	□ _____
Allergies- food/pets/seasonal	□	□ _____
Anemia/blood disorder	□	□ _____
Diabetes	□	□ _____
Ear infections/strep throat	□	□ _____
Genetic disorder	□	□ _____
Heart disease/defects	□	□ _____
Intestinal problems	□	□ _____
Neurological (headaches/seizures)	□	□ _____
Psychological (ADHD, autism, anxiety)	□	□ _____
Urinary tract infections/disorders	□	□ _____
Other chronic conditions	□	□ _____

Has your child ever been hospitalized overnight? □ Yes □ No Please explain and give dates _____

_____

Please list any specialist(s) your child is seeing _____

_____

Medications

Allergies to medications and reactions _____

Current medications and dose _____

_____

Vitamins, herbal supplements, over the counter medications _____

Surgical History

Type of surgery and date of surgery _____

Social History

Who lives in the household with your child? □ Parent (Mom) □ Parent (Dad) □ Siblings #_____ □ Other _____

Parent(s) □ Married □ Single □ Divorced □ Remarried Name of Step-parent_____

□ Custody (Please bring in custody papers if other than shared)

Smokers □ Yes □ No Pets □ Yes □ No What Kind? _____ Age of home_____

Does your child stay home with you? □ Yes □ No Does your child attend daycare/preschool/babysitter? □ Yes □ No

Developmental

At what age did your child: roll over _____ crawl _____ walk _____ speak 2 words _____

Present grade in school _____

Patients Race: □ American Indian or Alaska Native □ Asian □ White □ Hispanic □ Black or African American □ Native Hawaiian/Other Pacific Islander □ Other □ Decline to report

Patients Language: □ English □ Spanish □ Indian □ Russian □ Other _____

Patients Ethnicity: □ Hispanic or Latin □ Not Hispanic or Latin □ Decline to report