

ROLLING OAKS PEDIATRICS
WELCOME AND THANK YOU FOR COMING TO SEE US!

Family Name _____

Siblings (Name/DOB) _____ (Name/DOB) _____ (Name/DOB) _____

Siblings (Name/DOB) _____ (Name/DOB) _____ (Name/DOB) _____

Address _____ Phone # _____

City _____ Zip _____

Mother's Name _____ DOB _____ SS# _____ Occupation _____

Employed by _____ Phone # _____ Driver's Lic # _____

Father's Name _____ DOB _____ SS# _____ Occupation _____

Employed by _____ Phone # _____ Driver's Lic # _____

Who referred you to our office? _____

Nearest Realtive Not Living At Home _____ Relationship: _____

Address _____ Phone: _____

Family History: Please Print Clearly and fill in as completely as possible.

Drug Allergies:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Allergy _____ | <input type="checkbox"/> Colic _____ | <input type="checkbox"/> Hayfever _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Hearing Loss _____ | <input type="checkbox"/> Migranes _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Heart Trouble _____ | <input type="checkbox"/> Muscle Disease _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Blood Pres. _____ | <input type="checkbox"/> Nervous Condition _____ |
| <input type="checkbox"/> Birth Defects _____ | <input type="checkbox"/> Ear Trouble _____ | <input type="checkbox"/> Hives _____ | <input type="checkbox"/> Skin Conditions _____ |
| <input type="checkbox"/> Bone Disease _____ | <input type="checkbox"/> Easy Bleeding _____ | <input type="checkbox"/> Kidney Trouble _____ | <input type="checkbox"/> Stomach Ulcers _____ |
| <input type="checkbox"/> Breathing Issues _____ | <input type="checkbox"/> Eye Problems _____ | <input type="checkbox"/> Liver Disease _____ | <input type="checkbox"/> Thyroid Condition _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Foot Problems _____ | <input type="checkbox"/> Lung Disease _____ | <input type="checkbox"/> Urine Infections _____ |
| | | | <input type="checkbox"/> Other _____ |

INSURANCE INFORMATION; * Please give card to the receptionist to copy *

Insurance Name of Insured: _____ Policy # _____

Insurance Company: _____ Group # _____

Primary Care Physician: _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE BELOW.

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Driver's License #: _____

Social Security #: _____ Employer: _____

By the signature below, I hereby certify the correctness of the above information and authorize release of information to my insurance company. I assign benefits to Rolling Oaks Pediatrics. A photocopy of the assignment may serve as the original. I hereby agree that in consideration for services rendered by the doctor. I shall make prompt payment to may account as bills are presented. If it becomes necessary for the account to be referred to collective action, I shall pay the actual attorney's fees and collections expenses.

Signed _____

Patient of Responsible Party

Date