

# COBB PEDIATRIC ASSOCIATES

## PATIENT INFORMATION

PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_

GENDER M \_\_\_\_\_ F \_\_\_\_\_ (Check One)

S.S.# \_\_\_\_\_

PHONE # \_\_\_\_\_

## PARENT INFORMATION

FATHER /LEGAL GUARDIAN (circle one)

MOTHER /LEGAL GUARDIAN (circle one)

BIRTH DATE \_\_\_\_\_

S.S.# \_\_\_\_\_

ADDRESS (CHECK IF SAME AS PATIENT \_\_\_\_\_)

BIRTH DATE \_\_\_\_\_

S.S.# \_\_\_\_\_

ADDRESS (CHECK IF SAME AS PATIENT \_\_\_\_\_)

HOME PHONE # \_\_\_\_\_

WORK PHONE # \_\_\_\_\_

CELL PHONE # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

HOME PHONE # \_\_\_\_\_

WORK PHONE # \_\_\_\_\_

CELL PHONE # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

I.D. # (S.S. #) \_\_\_\_\_

GROUP # \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

I.D. # (S.S. #) \_\_\_\_\_

GROUP # \_\_\_\_\_

I authorize the release of any medical or other information necessary to process my child's insurance claim. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to Cobb Pediatric Associates, P.C. for services rendered and agree to the below stated method of payment and terms of payment.

SIGNATURE OF INSURED \_\_\_\_\_ DATE \_\_\_\_\_

## NEAREST RELATIVE OR PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

## HOW DID YOU HEAR OF COBB PEDIATRIC ASSOCIATES?

FRIEND \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

YELLOW PAGES \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_ OTHER \_\_\_\_\_

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## MEDICAL HISTORY

### FAMILY HISTORY

Siblings:			
	Name	Date of Birth	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Health Problems (note: F - Father, M - Mother, S - Sibling, GF - Grandfather, GM - Grandmother, A - Aunt, U - Uncle, C - Cousin)			
<input type="checkbox"/> Heart Attack or Stroke at age less than 60 _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Cancer (list type) _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Sudden Death _____	<input type="checkbox"/> Allergies _____	_____
<input type="checkbox"/> ADHD _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Anemia _____	_____
	<input type="checkbox"/> Seizures _____	<input type="checkbox"/> Other _____	_____

### CHILD'S HEALTH HISTORY

Birth: _____	Weight: _____	Type of Delivery: _____
Newborn Problems: _____		
_____		
Hospitalization/Surgery: _____		
_____		
Are immunizations up to date? _____		
Current Medications: _____		
Check appropriate items child has had in past:		
<input type="checkbox"/> Bronchiolitis	<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Urinary Infection
<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures	<input type="checkbox"/> Allergies
<input type="checkbox"/> ADHD	<input type="checkbox"/> Eczema	<input type="checkbox"/> Chicken Pox
		<input type="checkbox"/> Other _____
Has your child had any problems in his/her development? _____		
_____		

### SOCIAL HISTORY

Household Members: _____
Any smokers in the home? (N/Y) _____ Any Pets? _____
Childcare: <input type="checkbox"/> Attends school/preschool <input type="checkbox"/> Attends daycare (if yes, circle one: full time or part time) <input type="checkbox"/> Stays home
Any other important information about your child: _____
_____