Agape
Family Medical Center

PEDIATRIC NEW PATIENT INTAKE FORM

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Home Phone: (_____)_____-_____ Mobile Phone: (_____)_____-_____
Preferred (circle) : Home / Cell Email: _____ Gender: _____
Primary Pediatrician: _____ Phone: (_____)_____-_____
Pediatrician Address: _____
Referring Provider: _____ Phone: (_____)_____-_____
Referring Address: _____
Preferred Pharmacy: _____ Phone: (_____)_____-_____
Preferred Pharmacy Address: _____
Parent 1 Name: _____ DOB:_____ Phone: (_____)_____-_____
Email: _____ Address: _____
Occupation: _____ Marital Status: _____ Spouse:_____
Parent 2 Name: _____ DOB:_____ Phone: (_____)_____-_____
Email: _____ Address: _____
Occupation: _____ Marital Status: _____ Spouse:_____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity: Race:

□ Decline Response □ Hispanic or Latino □ Not Hispanic or Latino
□ American-Indian or Alaska Native □ Asian □ White/Caucasian
□ Black or African American □ Native Hawaiian or Pacific Islander □ Other
□ Preferred Language: _____ □ Decline Response

Insurance Information

Health Insurance Company: _____ ID # _____ Group # _____
Secondary Insurance: _____ ID # _____ Group # _____
Policy Holder Name & DOB (if different from patient): _____
Other If Applicable (circle type): Work Comp, Auto Accident. Please fill out all applicable information below:
Insurance Company: _____ Phone Number: _____ Address: _____
Date of accident: _____ Claim Number: _____ Adjuster's Name: _____
Adjuster's Phone Number: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Agape Family Medical Center for services rendered. I authorize representatives of Agape Family Medical Center to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Agape Family Medical Center Notice of Privacy Practices (NOPP).
□ Received □ N/A (only if you received the notice from Agape Family Medical Center previously)

Patient or Legal Guardian Name (Print): _____
Patient or Legal Guardian Signature: _____ Date:_____

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Medical and Social History

Reason for today's visit: _____

_____

Is patient adopted? ☐ Y ☐ N If 'Y', please answer the following to the best of your knowledge.

Which pregnancy is patient? _____ Birth weight: _____ Born by: ☐ C-Section ☐ Vaginal Delivery

Weeks' gestation at birth? _____ If C-section, why? _____

Please describe any health problems the mother or patient experienced during pregnancy or after birth, if any:

_____

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? ☐ Y ☐ N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Please list ALL current medications, including over-the-counter, supplements, and herbs

Medication Name	Dose	Medication Name	Dose

Please list any past surgeries and hospitalizations and the approximate date.

Procedure/surgery	Date

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Has the patient EVER had any of the following?

Anemia/Bleeding tendency ..... ☐ Y ☐ N
Asthma/Breathing problems ..... ☐ Y ☐ N
Behavioral problems..... ☐ Y ☐ N
Blood Transfusion..... ☐ Y ☐ N
Bowel/Stomach problems ..... ☐ Y ☐ N
Cancer/Leukemia ..... ☐ Y ☐ N
Chicken Pox/Shingles ..... ☐ Y ☐ N
Developmental disorder..... ☐ Y ☐ N
Diabetes ..... ☐ Y ☐ N
Ear/Nose/Throat..... ☐ Y ☐ N
Eczema/Skin disorder..... ☐ Y ☐ N
Eye Disorder ..... ☐ Y ☐ N
Growth disorder..... ☐ Y ☐ N
Heart disorder/defect ..... ☐ Y ☐ N
Kidney/Bladder problems ..... ☐ Y ☐ N
Liver disease ..... ☐ Y ☐ N
Seizure or Epilepsy ..... ☐ Y ☐ N
Thyroid disorder ..... ☐ Y ☐ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

Relative	Condition and description	Living?
Parent		□ Y □ N
parent		□ Y □ N
Sibling		□ Y □ N
Other		□ Y □ N

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to patient

Patient Social History Does anyone living in your home smoke? □ Y □ N Do you have pets? □ Y □ N
Do you smoke? □Y □N □Never If Y, Packs/day _____ If N, previously? □Y □N Yrs smoked ____ Packs/day ___
Do you use other tobacco products? □Y □N Consume alcohol? □Y □N If Y, drinks/week _____ For Females:
Menses? □Y □N If Y, at what age? _____

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REVIEW OF SYSTEMS

Please indicate ALL that the patient has experienced within the past 6 – 12 months.

Constitutional

☐Y☐N Fever ☐Y☐N Fatigue ☐Y☐N Weight Gain (___ Lbs) ☐Y☐N Sleep Disturbances
☐Y☐N Chills ☐Y☐N Feeling Poorly ☐Y☐N Weight Loss (___ Lbs) ☐Y☐N Sweats
☐Y☐N Unexp. Weight Change ☐ Other:

Head, Eyes, Ears, Nose, and Throat

☐Y☐N Vision Problem ☐Y☐N Red Eyes ☐Y☐N Congestion ☐Y☐N Hoarseness
☐Y☐N Decreased Hearing ☐Y☐N Double Vision ☐Y☐N Light Sensitivity ☐Y☐N Itchy Eyes
☐Y☐N Eye Pain ☐Y☐N Snoring ☐Y☐N Ringing in Ears ☐Y☐N Nosebleed
☐Y☐N Runny Nose ☐Y☐N Dry Mouth ☐Y☐N Vertigo ☐Y☐N Sore Throat
☐Y☐N Neck Stiffness ☐Y☐N Flu-Like Symptoms ☐Y☐N Earache ☐Y☐N Other:

Cardiovascular

☐Y☐N Chest Pain ☐Y☐N Cold Extremities ☐Y☐N Irregular Heart Rhythm
☐Y☐N Palpitations ☐Y☐N Cold Hands or Feet ☐Y☐N Other:
☐Y☐N Leg Swelling ☐Y☐N Leg Pain w/ Walking

Respiratory

☐Y☐N Shortness of Breath ☐Y☐N Wheezing ☐Y☐N Coughing Up Blood
☐Y☐N Cough ☐Y☐N Shortness of Breath ☐Y☐N Coughing Up Sputum
☐Y☐N Rapid Breathing ☐Y☐N Chest Congestion ☐ Other:

Gastrointestinal

☐Y☐N Abdominal Pain ☐Y☐N Diarrhea ☐Y☐N Change in Bowels ☐Y☐N Painful Swallowing
☐Y☐N Blood in Stool ☐Y☐N Black/Tarry Stools ☐Y☐N Vomiting Blood ☐ Other:
☐Y☐N Vomiting ☐Y☐N Decreased Appetite ☐Y☐N Bowel Incontinence
☐Y☐N Nausea ☐Y☐N Yellow Skin ☐Y☐N Rectal Pain
☐Y☐N Constipation ☐Y☐N Trouble Swallowing ☐Y☐N Heartburn

Neurological

☐Y☐N Headache ☐Y☐N Unsteady ☐Y☐N Numbness ☐Y☐N Tremor
☐Y☐N Dizziness ☐Y☐N Disorientation ☐Y☐N Tingling ☐Y☐N Memory Lapses/Loss
☐Y☐N Decreased Strength ☐Y☐N Confusion ☐Y☐N Seizures ☐ Other:
☐Y☐N Poor Coordination ☐Y☐N Burning Sensation ☐Y☐N Fainting (Syncope)

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Musculoskeletal

☐Y☐N Joint Pain ☐Y☐N Limb Pain ☐Y☐N Muscle Pa ☐ Other:
☐Y☐N Neck Pain ☐Y☐N Joint Swelling ☐Y☐N Muscle Weakness
☐Y☐N Back Pain ☐Y☐N Muscle Cramps ☐Y☐N Leg Swelling

Genitourinary

☐Y☐N Frequent Urination ☐Y☐N Pelvic Pain ☐Y☐N Painful Intercourse ☐Y☐N Heavy Period Bleeding
☐Y☐N Incontinence ☐Y☐N Nocturia ☐Y☐N Discharge- Vaginal ☐ Other:
☐Y☐N Urinary Urgency ☐Y☐N Itching- Genital ☐Y☐N Vaginal Bleeding
☐Y☐N Painful Urination ☐Y☐N Change in Libido ☐Y☐N Irreg. Monthly Cycles

Integumentary

☐Y☐N Rash ☐Y☐N Skin Wound ☐Y☐N Unusual Growth ☐Y☐N Skin Cancer
☐Y☐N Dry Skin ☐Y☐N Change in A Mole ☐Y☐N Itching ☐ Other:

Psychiatric

☐Y☐N Depression ☐Y☐N Anxiety ☐Other:

Hematologic/Lymphatic

☐Y☐N Easy Bruising ☐Y☐N Easy Bleeding ☐Y☐N Swollen Lymph Nodes ☐ Other:

Endocrine

☐Y☐N Excessive Thirst ☐Y☐N Heat Intolerance ☐Y☐N Changes- Skin
☐Y☐N Cold Intolerance ☐Y☐N Changes- Hair ☐ Other: