Pediatric Medical Group
OF RIVERSIDE, INC.

INITIAL PEDIATRIC HEALTH ASSESSMENT

Name of Child	Today's Date	Chart#
Date of Birth	Mother Age:	Historical Source
Age Now: Sex:	Father Age:	Siblings:

BIRTH HISTORY

Hospital, City, State		Pregnancy/delivery problems?
Delivery Type		Post Partum complications?
Was baby discharged with mother? [ ] Yes [ ] No		Why not?
Birthweight Ibs. oz.	Length	[ ] Breast [ ] Formula

MEDICAL HISTORY

**** Allergies** to food, medications, or environmental antigens?	
Hospitalizations	
Surgeries	
Injuries/ Accidents	
Significant Illnesses	

Child has had:

- ☐ Chicken Pox
- ☐ Mumps
- ☐ Measles
- ☐ TB
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Any other problems _____
- ☐ Colic / Abdominal Pain
- ☐ Seizures
- ☐ Headaches
- ☐ Pneumonia
- ☐ Bladder Infections
- ☐ Sickle Cell Disease/Trait
- ☐ Heart Murmur
- ☐ Sinus Problems
- ☐ Ear Infections
- ☐ Hay Fever
- ☐ Eczema
- ☐ Anemia

Present Medications:	Other Concerns:
Language spoken at home	Exposure to tobacco smoke ?
Primary Caretaker of child	Alcohol, other drug contacts ?

FAMILY MEDICAL HISTORY

Blood relative has had:

- ☐ Anemia
- ☐ Sickle Cell Disease/Trait
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Drug Abuse
- ☐ Alcoholism
- ☐ Other _____
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Birth Defects
- ☐ Deafness
- ☐ Mental Retardation
- ☐ Hay Fever
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Eczema
- ☐ High Blood Pressure
- ☐ Cancer

FAMILY DATA SHEET

Acct. # _____

Date _____

CHILDREN *(living at home)*

	First Name	Last Name	Date of Birth
1.			
2.			
3.			
4.			
5.			
6.			

SPECIAL MEDICAL DATA

Home Address: _____
STREET CITY ZIP

Home Phone: _____ Referred By: _____ Phone: _____

Friend or Relative in Area _____ Phone: _____

FATHER

NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ DRIVERS LIC.# _____

EMPLOYER _____ WORK PHONE _____

MOTHER

NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ DRIVERS LIC.# _____

EMPLOYER _____ WORK PHONE _____

INSURANCE

#1 PRIMARY INSURANCE CO. NAME _____ ID# _____ PLAN _____ GROUP _____

SUBSCRIBER'S NAME _____ RELATIONSHIP _____ SUBSCRIBER'S EMPLOYER _____

#2 SECONDARY INSURANCE CO. NAME _____ ID# _____ PLAN _____ GROUP _____

SUBSCRIBER'S NAME _____ RELATIONSHIP _____ SUBSCRIBER'S EMPLOYER _____

TREATMENT AUTHORIZATION

TO: PEDIATRIC MEDICAL GROUP OF RIVERSIDE, INC.

In the absence of either or both of the undersigned, you are hereby authorized and instructed to perform any necessary or convenient medical services which might be required for the above-listed children, without any further authorization or consent upon the part of the undersigned.

This authorization extends to hospitalization and/or surgery, your employment of such other medical doctors that are either necessary or desirable to assist you, and providing for nursing and other medical or incidental services which might be required.

Signed: _____
PARENT(S) / GUARDIAN(S)

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT AUTHORIZATION

I hereby authorize the release of any information required by my insurance company and I request that payments be made directly to:

PEDIATRIC MEDICAL GROUP OF RIVERSIDE

Signed: _____

Date: _____