CHI St. Joseph Health

Patient Registration Form

Patient Legal Name: _____
Last Name First Name Middle Initial

Address: _____
Street or Box City Zip Code

Phone: (Primary)_____(Cell)_____(Work)_____

Driver's License #:_____ DOB: _____

Email: _____

Spouse Name: _____ DOB: _____

Gender: ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Legally Separated
☐ Divorced ☐ Widow/Widower ☐ Unknown

Employment Status: ☐ Full Time ☐ Part time Employer: _____

Student: ☐ Full Time ☐ Part time ☐ N/A School: _____

Race: ☐ American-Indian or Alaska-Native ☐ White ☐ Asian ☐ Native Hawaiian
☐ Black or African-American ☐ More than One Race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Language Spoken: _____

Religion: _____ Referred By: _____

Insurance: _____ Patient Insurance ID Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Emergency Contact Name:_____Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Name of Preferred Local Pharmacy: _____ Telephone: _____

Pharmacy Address: _____

Mail Order Pharmacy: _____

How do you prefer to receive communications from our clinics (check all that apply):

☐ Phone Call ☐ Text ☐ Patient Portal/Email ☐ Letter

Primary Care Physician: _____Telephone:_____

Please complete if PATIENT is a student or minor:

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

Address: _____ Phone: _____

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

Address: _____ Phone: _____

St. Joseph's Pediatric Clinic
Health information form
Newborn to 5 years

Child's Name: _____ **Date of birth:** _____ **Age:** _____

Birth History:

Age of mother at time of birth: _____ Place of birth (hospital, city): _____
Was your child born: ❑full-term ❑ pre-term (more than 3 weeks before due date)
Type of delivery: ❑ VAGINAL or ❑ C-SECTION; was labor "induced": ❑YES ❑ NO
Medications taken during pregnancy: _____
Medical complications of pregnancy:

____ Vaginal bleeding
____ Anemia
____ Hypertension
____ Blood problems
____ Diabetes
____ Exposure to TB
____ Dental disease
____ Flu-like illness or high temperature
____ Kidney or bladder infection
____ Sexually transmitted diseases (gonorrhea, etc)
____ Hepatitis
____ Preterm labor
____ Exposure to lead/chemicals
____ Injury or hospitalization

Baby's birth weight: _____ pounds, _____ounces
Hold old was the baby at the time of discharge from the hospital: _____
Any problems for baby during the hospital stay?: ❑YES ❑ NO List: _____
(include any infections, jaundice, failed hearing screen, heart murmur, breathing problems)
Did your baby get hepatitis B vaccine in hospital? ❑YES ❑ NO Did your baby pass the hearing screen? ❑YES ❑ NO

Infant/Child Medical history:

List any known drug allergies:_____ ❑ None Are immunizations Current?: ❑YES ❑ NO
Any chronic medical problems (circle all that apply)? ❑ NONE or anemia, ear infections, vision problems, hearing problems, seizures/epilepsy, bladder/kidney infections, pneumonia, bronchitis, allergies, asthma, eczema, lead exposure, other _____
Does your child take any medications routinely? ❑YES ❑ NO if yes, please list _____
List any surgeries, fractures or injuries: _____
Has your child ever had to be hospitalized? ❑YES ❑ NO if yes, please explain:_____
Has your child had any developmental problems? ❑YES ❑ NO if yes, please explain _____

Family Medical History:

(CHECK ALL THAT APPLY)

	Mom	Dad	Siblings	Aunts	Uncles	Grandmothers		Grandfathers	
						Mom's Family	Dad's Family	Mom's Family	Dad's Family
Anemia/Blood disorder									
Heart disease									
High cholesterol									
High blood pressure									
Stroke									
Cancer									
Diabetes									
Epilepsy/seizures									
Kidney problems									
Genetic diseases/ birth defects									
Childhood hearing Problems									
TB/tuberculosis									
Asthma/Allergies									

Social history:

Who currently lives in your home? ❑ Mom ❑ Dad ❑ Brother/Sister(s) #_____ ❑ Grandmother ❑ Grandfather
❑ Others: _____ List any type of pets in your home: _____
Does anyone smoke at home? ❑YES ❑ NO Does your child attend daycare? ❑YES ❑ NO

St. Joseph
Physician Associates

Non- Parent/Guardian Authorization for Consent to Medical Care and Treatment

I, _____, the parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named person(s) to consent to the medical care and treatment of my child(ren). I hereby authorized and grant that the below named person(s) has/have permission from the natural parent or legal guardian to sign for any and all medical procedures or treatments deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have the authority to consent for all medical care and treatment of said child(ren).

This authorization is for:

- □ Today's date only.
- □ A specific date of: _____.
- □ All future visits effective for one year from today's date.

I realize that it is my duty to update and notify my physician's office of any necessary changes that must be made to this document within a timely manner. I also understand that to ensure this document is accurate I will be required to complete it annually.

_____	_____	_____
Signature	Relationship to child(ren)	Date

Child(ren):

_____	_____	_____
Name	Name	Name
_____	_____	_____
Name	Name	Name

Person(s) who are authorized to seek medical care for the child(ren) listed above:

_____	_____
Name	Relationship to the child(ren)
_____	_____
Name	Relationship to the child(ren)
_____	_____
Name	Relationship to the child(ren)