THE CHILDREN'S CLINIC OF CLEAR LAKE

FAMILY HISTORY

BIRTHDATE_____NAME_____

MOTHER_____MISCARRIAGES_____MONTH_____CAUSE_____

FATHER_____TUBERCULOSIS_____TBC CONTACTS_____

SIBLINGS_____ALLERGY_____

SIBLINGS_____DIABETES_____CONVULSIVE DISEASE_____

SIBLINGS_____MOTHER'S BLOOD TYPE_____RH____BABY'S BLOOD TYPE_____

BIRTH AND DEVELOPMENT

TERM (WEEKS)_____DELIVERY_____BIRTH WEIGHT_____

CONDITION AT BIRTH_____HOSPITAL DISCHARGE WEIGHT_____

FEEDING: BREAST_____Y_____N FORMULA_____Y_____N TYPE:_____

MEDICAL HISTORY

Medical conditions:

_____

(example: Asthma)

When:_____

Hospitalizations/Surgeries: Where_____When_____Why_____

Home Medications: Name of med_____Dosage_____

Allergies to food, latex, medications:_____

What kind of reaction (rash, difficulty breathing, itching, etc.)_____

AUTHORIZATION AND ACKNOWLEDGMENT

Do you have a living will (advance directive)? ( )N ( )Y

I/We hereby state that the above information is true and correct to the best of my/our knowledge. I/We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors as required for certain claims filed. My/Our signature also signifies my/our consent to medical treatment deemed necessary by the physician and/or the office staff under the physician's direction.

_____

Signature of Patient/Parent/Guardian Printed Name Date

I/We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

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Signature of Patient/Parent/Guardian Printed Name Date