MRN _____

BROADWAY MEDICAL CLINIC
PEDIATRIC PATIENT INTAKE FORM
(Please print clearly)

Child's full legal name _____

Name or nickname child likes to be called _____

Date of birth _____ Birth sex **(circle one)** F M Identified gender _____

Which pediatrician are you establishing care with? _____

Would you like to identify your child's race/ ethnicity for our data collection? **(circle one)** Yes No

(If yes, circle all that apply) Asian Black/African American Caucasian Hispanic/Latino Native American Other

How did you hear about BMC (if referred by a patient/parent, please give name) (**circle one)** Radio Ad TV Person Other

Referred by (if applicable):_____

PARENT INFORMATION	**PARENT 1**	**PARENT 2**
Full Legal Name		
Date of Birth		
Address		
City/State		
Zip Code		
Home Phone		
Mobile Phone		
Employer Name/ Occupation		
Employer Phone		
Email address **(please write legibly)**		

Parent's Marital Status **(circle one)** Married Separated Divorced Unmarried Widowed

Primary address of the child **(circle all that apply)** Parent 1 Parent 2

Parent with medical decision making rights for child **(circle all that apply)** Parent 1 Parent 2

Other Primary Caregiver or Guardian (and role) _____

***Please provide copies of court orders related to primary residence, custody, decision making authority ***

We must have a signed consent on file for any other person than biological parents bringing child to appointments

EMERGENCY CONTACT - RELATIVE TO PARENTS (please list two)	
Name	
Relationship to patient	
Home phone	
Cell phone	
Name	
Relationship to patient	
Home phone	
Cell phone	

PLEASE COMPLETE BOTH SIDES OF INTAKE FORM

SOCIAL HISTORY
Names and ages of siblings (year of birth)
Who lives in the family home?
Does your child attend daycare? **(circle all that apply)** Yes No nanny full time part time
Smokers around child (Include outside smokers)? Yes / No father mother brother sister GF GM friend daycare
Pets in home? Yes / No dog(s) cat(s) fish birds gerbils hamster other:
Guns in Home? Yes / No Guns are kept **(circle all that apply)** Unloaded Locked Ammunition Stored Separately
Within the last 12 months we worried whether or not our food would run out before we had money to buy more **(circle one)** Yes No
Within the past 12 months the food we bought did not last and we didn't have money to buy more **(circle one)** Yes No

PRENATAL AND BIRTH HISTORY (if known)	
Any illnesses or complications during pregnancy? Yes No	Any complications at time of delivery or after birth? Yes No Hospital (name, town/state):
Any smoking, alcohol or recreational drug use during pregnancy? Yes No	
Mother's OB doctor and clinic:	Birth weight:
	Were you seen in hospital by our BMC doctors? Yes No

PAST MEDICAL HISTORY	
Child's Previous Doctor (name, town/state): Have you requested records be sent to BMC? Yes No	Are immunizations up to date? Yes No Unknown Have you given us a copy of immunization report? Yes No
Hospitalizations/Surgeries **(circle one)** Yes/No **(list below if "yes")**	Food Allergy **(circle one)** Yes / No **(list below if "yes")**
1.)	1.)
2.)	2.)
Prior Problems **(circle one)** Yes/No **(list below if "yes")**	Medication Allergy **(circle one)** Yes / No **(list below if "yes")**
1.)	1.)
2.)	2.)

FAMILY HISTORY	
Does any member of the **CHILD'S IMMEDIATE** family have any of the following conditions? If so, please circle and tell us who: **PGF = dad's father, PGM = dad's mother, MGF = mom's father, MGM = mom's mother, Uncle = child's uncle, Aunt = child's aunt, S = child's sister, B = child's brother, Mom = Mother, Dad = Father**	
Anesthesia Reactions	Heart Attack
Bleeding Disorders (hemophilia, VonWill)	High Blood Pressure
ADD/ADHD	High Cholesterol
Allergies	Kidney Stones
Anxiety	Osteoporosis ("bone softening")
Asthma	Overweight
Autism/Asperger's	Rheumatoid Arthritis
Cancer **(list type)**	Seizures/Epilepsy
Congenital Heart Disease	Sudden Infant Death (SIDS)
Coronary Artery Disease	Stroke/Cerebrovascular Accident
Depression	Sudden Cardiac Death
Diabetes	Thyroid Disease
Drug/Substance Abuse	Ureteral/Kidney Reflux
Food Allergies	Other Concerns/Issues
HIV/AIDS	

Reviewed by MD_____