HARTLAND PEDIATRICS

10850 Highland Rd. Hartland, MI 48353 Ph: (810) 632-3200

Current Patient Information

Name: _____
Date of Birth: _____/_____/_____
Sex: ☐ Male ☐ Female
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone Number: _____
School/Daycare: _____

Contact Preference: (Please choose one)
☐ Home Phone ☐ Mobile Phone
☐ Work Phone ☐ Email ☐ Mail

Is this child adopted? ☐ Yes ☐ No

Mother or Legal Guardian's Information:
Name: _____
Phone: _____
Home Address: _____
_____
Date of Birth: _____
E-Mail Address: _____

Dad or Legal Guardian's Information:
Name: _____
Phone: _____
Home Address: _____
_____
Date of Birth: _____
E-Mail Address: _____

Child lives with:
☐ Mother ☐ Father
☐ Stepparent ☐ Family
☐ Other: _____

Language: _____

Ethnicity: ☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Decline to answer

Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian/White
☐ Hawaiian or Pacific Islander
☐ Decline to answer

Insurance Information

Primary Insurance:
Insurance Plan Name: _____
Subscriber's Name: _____
Date of Birth: _____/_____/_____
Sex: ☐ Male ☐ Female
Employer's Name: _____
Patient's relationship to policy holder:
_____

Secondary Insurance:
Insurance Plan Name: _____
Subscriber's Name: _____
Date of Birth: _____/_____/_____
Sex: ☐ Male ☐ Female
Employer's Name: _____
Patient's relationship to policy holder:
_____

Child's Allergies (Include date if known):
_____

Child's Medication (Include dose if known):
_____
_____

Pharmacy Name & Phone Number:
_____
_____

Other side ➡

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Child's Long-Term/Chronic Medical Concerns

Illness	Date of Diagnosis

Child's Surgery History

Surgery	Date of Surgery

Check family members who have the following conditions	No History	Mother	Father	Maternal GM	Maternal Gf	Paternal GM	Paternal Gf
Alcoholism/Substance abuse							
Allergies/Asthma							
Anemia/Blood disease							
Cancer: type_____							
Depression							
Diabetes (type I or type II)							
Heart problems							
High Blood Pressure							
High Cholesterol							
Migraines							
Obesity							
Seizures/epilepsy							
Stroke							
Other: _____							

Child's Birth History

Birth weight _____ Birth height _____ Birth Head Circumference _____ Discharge Weight _____
Gestational Age _____ Cesarean Section or Vaginal Birth (circle one)
Primary Nourishment: □unknown □bottle-fed □breast-fed

Immunization status:
☐ Up-to-date ☐ Some needed ☐ Some/all done out-of-state ☐ Do not immunize

Other side ➡

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- I acknowledge receiving a copy of Hartland Pediatrics Notice of Privacy Practices.
- I attest that all the information provided is the most complete and up-to-date information for my child. If any of this information changes, I will notify Hartland Pediatrics.

_____ _____

Printed name of authorized representative (if applicable) Relationship to patient

_____ _____

Signature of patient or authorized representative Date

How did you hear about us?

☐ Facebook ☐ Website ☐ Google ☐ OB/Hospital

☐ Person (Name) _____ ☐ Other: _____