Integrity Health Group

New Patient Registration Form

PATIENT INFORMATION:

Patient Name: ______________________________ Sex: M F

Address: ______________________________

City: ______________________ NY Zip: ______________

Birthdate: ______________________

Telephone: ______________________

Ethnicity: White Black/African American Asian Other: ______________

Race: Spanish/Hispanic Non Hispanic

Primary Language: ______________

Mother's Name: ______________ Maiden Name: ______________

Address (If Different): ______________________________

City: ______________________ NY Zip: ______________

Birthdate: ______________________

Telephone: ______________________

Father's Name: ______________________________

Address (If Different): ______________________________

City: ______________________ NY Zip: ______________

Birthdate: ______________________

Telephone: ______________________

Guardian (If Other Than Natural Born Parent): ______________________

Relationship: ______________________________

Patient Lives With: ❑ Both Parents: ❑ Mother ❑ Father ❑ Guardian

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Health Insurance: ______________ Subscriber ID #: ______________

Policy Holder Name: ______________ DOB: ______________

Primary Pharmacy: ______________ Address: ______________ Phone#: ______________

Most Recent Health Care Provider: ______________________________

Last Routine Well Visit Date: ______________________________

Has child ever been a patient of Integrity Health Group? (Tonawanda, Transit/Meadow, Island Peds)
( )yes ( ) no

BIRTH HISTORY:

Pregnancy Complications: ______________________________

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Delivery:

Hospital: ______________________ ( )Vaginal ( ) C-Section Gestational Age: __________

Birth Weight: ______________ Length of Stay: ______________

Complications: ______________________________

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HOSPITALIZATIONS:

	Date	Illness	Hospital	Length of stay
1.				
2.				
3.				

SURGERIES:

	Date	Surgery	Hospital	Length of Stay
1.				
2.				
3.				

MEDICAL: Please check if child has had the following

( ) Chicken Pox
( ) Seasonal Allergy
( ) Asthma
( ) Pneumonia
( ) Heart problems
( ) Mononucleosis
( ) Hives
( ) Elevated lead
( ) Anemia
( ) Broken Bones
( ) Burns
( ) TB Exposure
( ) Urinary Tract Infection
( ) Fainting
( ) Eczema/Skin Rash
( ) Seizures
( ) Head Trauma/ Concussion
( ) Headaches/Migraines
( ) Depression/Anxiety

Other: ______________________________

MEDICATIONS:

Name	Dosage	Frequency

ALLERGIES: (food or medication, include type of reaction)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

IMMUNIZATIONS: up to date ( ) yes ( ) no (provide copy of record)

HABITS:

YES	NO		YES	NO	
( )	( )	Uses car seat/seat belt	( )	( )	Trouble with hearing
( )	( )	Trouble with vision	( )	( )	Breathing problems
( )	( )	Routine dental exams	( )	( )	Easily fatigued/tired
( )	( )	Brushes teeth regularly	( )	( )	Feeding problems
( )	( )	Frequent Colds	( )	( )	Bed Wetting
( )	( )	Frequent Sore Throats	( )	( )	Urinary problems
( )	( )	Frequent Ear Infections	( )	( )	Easy bruising/bleeding
( )	( )	Constipation	( )	( )	Severe/frequent headaches
( )	( )	Frequent Abdominal Pain	( )	( )	Behavior problems
( )	( )	Frequent muscle/joint pain /swelling	( )	( )	School/Learning problems
( )	( )	Rashes	( )	( )	Stress in family

OTHER INFORMATION THE DOCTOR SHOULD BE AWARE OF:

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Integrity Health Group

SOCIAL HISTORY:

Primary Household | **Secondary Household (if applicable)**

Caretaker(s): ____________________ | ____________________

Others in house: ____________________ | ____________________

____________________ | ____________________

Pets: ____________________ | ____________________

Smoking in House: ( )yes ( ) no | ( ) yes ( ) no

School: ____________________ Grade: ____________________

Daycare: ____________________

FAMILY HISTORY

	PRINT NAME OF CHILD'S RELATIVE, LIVING OR DECEASED AND YEAR OF BIRTH FIRST LAST NAME	ALLERGIES	ASTHMA	BLEEDING TENDENCY	CANCER	DIABETES	EPILEPSY	SUDDEN DEATH/UNKNOWN CAUSE	MENTAL RETARDATION	HIGH BLOOD PRESSURE	KIDNEY DISEASE/BLADDER INFECTION	DEPRESSION/ANXIETY/MENTAL ILLNESS	RHEUMATISM/ARTHRITIS	ULCER/GI PROBLEMS	STROKE	TUBERCULOSIS	BIRTH DEFECTS	HEART DISEASE	HIGH CHOLESTEROL	HIP DYSPLASIA	DEATHS If relative listed has died, list cause and age of death	AGE
FATHER																						
MOTHER																						
BROTHER and/or SISTER																						
GRAND-PARENTS																						

OTHER FAMILY ILLNESS (PLEASE LIST)

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RETURN TO ONE OF THE FOLLOWING OFFICES:

Tonawanda Pediatrics
Integrity Health Group
Northwoods Medical Center
3950 E. Robinson Road
Suite 205
West Amherst, NY 14228

Island Pediatrics
Integrity Health Group
2271 Grand Island Blvd.
Grand Island, NY 14072

Transit Meadow Pediatrics
Integrity Health Group
East Amherst Medical Park
6477 Transit Road
East Amherst, NY 14051