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: _____

_____

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

Medical Conditions	Yes or No	Who?	Details
ADD/ADHD	□ Yes □ No		
Asthma/Wheezing	□ Yes □ No		
Allergies	□ Yes □ No		
Anemia	□ Yes □ No		
Alcoholism Drug Abuse	□ Yes □ No □ Yes □ No		
Autism	□ Yes □ No		
Autoimmune Disorders -rheumatoid arthritis -lupus	□ Yes □ No □ Yes □ No □ Yes □ No		
Birth defects	□ Yes □ No		
Blood disorder -bleeding/clotting problems -sickle cell -anemia -thalassemia	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No		
Cancer -**type**: _____	□ Yes □ No		
Diabetes	□ Yes □ No		
Eczema	□ Yes □ No		
Family Violence	□ Yes □ No		
Gastrointestinal Disorders -celiac -inflammatory bowel disease -irritable bowel/reflux	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No		
Hearing Loss	□ Yes □ No		
Heart attack/disease -sudden cardiac death -stroke	□ Yes □ No □ Yes □ No □ Yes □ No		
High blood pressure	□ Yes □ No		
High cholesterol	□ Yes □ No		
Inherited/Genetic diseases	□ Yes □ No		
Kidney Disease	□ Yes □ No		
Liver Disease/Hepatitis	□ Yes □ No		
Mental Illness -Depression -anxiety -suicide attempts	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No		
Mental Retardation	□ Yes □ No		
Migraines	□ Yes □ No		
Seizures	□ Yes □ No		
Thyroid disease	□ Yes □ No		

Has anyone in the family had an unexpected death under the age of 50?

_____

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OTHER FAMILY ILLNESS (PLEASE LIST)

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Primary Household	**Secondary Household (if applicable)**
Caretaker(s): _____	_____
Others in house: _____	_____
_____	_____
Pets: _____	_____
Smoking in House: ( ) yes ( ) no	( ) yes ( ) no

School: _____ Grade: _____

Daycare: _____

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