WESTERN VALLEY FAMILY PRACTICE, P.C.

PEDIATRIC INFORMATION SHEET (17 YEARS AND UNDER)

PLEASE COMPLETE THE QUESTIONNAIRE IN FULL, IF YOU HAVE NO INFORMATION TO PROVIDE, WRITE "NONE" OR "N/A". INCOMPLETE QUESTIONAIRES WILL NOT BE ACCEPTED. PLEASE USE THE BACK IF ADDITIONAL ROOM IS NEEDED.

IF YOU NO-SHOW YOUR 1ST VISIT YOU **WILL NOT** BE RESCHEDULED.

Requesting Doctor:________________________Male or Female **Facility:__________Redlands or Fruita_________**

How did you hear about us:___________________________________ (PLEASE CIRCLE YOUR PREFERENCE)

PATIENT'S INFORMATION			
Name:	E-Mail:	Race (optional):	
Date of birth:	Male or Female	SSN:	Phone:
Alternate Phone:	Preferred Pharmacy:	Previous Provider:	
Mailing Address:	City:	State:	ZIP Code:
Physical Address	City:	State:	Zip Code
Insurance Name:	ID#:	Policy Holder:	School/Grade:

MOTHER'S INFORMATION			
Name:	E-Mail:	SSN:	
Date of birth:	Phone:	Alternate Phone:	Employer:
Mailing Address (if different from patient):	City:	State:	ZIP Code:
Physical Address (if different from patient):	City:	State:	Zip Code

FATHER'S INFORMATION			
Name:	E-Mail:	SSN:	
Date of birth:	Phone:	Alternate Phone:	Employer:
Mailing Address(if different from patient):	City:	State:	ZIP Code:
Physical Address(if different from patient):	City:	State:	Zip Code

COMPLETE LIST OF CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS SEE BACK ☐ SEE ATTATCHED ☐			
1.	Dose:	2.	Dose:
3.	Dose:	4.	Dose:

DOES YOUR CHILD HAVE ANY ALLERGIES? (I.E. MEDICATIONS - HAYFEVER) SEE BACK ☐ SEE ATTATCHED ☐			
1.	Reaction:	2.	Reaction:
3.	Reaction:	4.	Reaction:

BACKGROUND INFORMATION						
Do you choose to vaccinate your child?	YES	NO	If yes, please include vaccination record.	How much did you child weigh at birth?	lbs.	oz.
Any maternal complications during pregnancy?	YES	NO	If yes, explain:			
Any complications of Labor or Delivery?	YES	NO	If yes, explain:			
Did baby go home directly after birth?	YES	NO	If no, explain:			

DO ANY OF THE FOLLOWING APPLY TO YOUR CHILD? (PLEASE WRITE YES OR NO) SEE BACK ☐ SEE ATTATCHED ☐					
Frequent Ear Infections:	Rheumatic Fever:	Frequent Bronchitis:			Behavior Concerns:
Mood Concerns:	Kidney or Bladder Infections:	Meningitis:			Concussion:
Seizures:	Chicken Pox:	Surgery (Type)			
Other:	Has your child ever been in the hospital overnight?	YES	NO	If yes, explain:	

FAMILY HISTORY (PLEASE INDICATE RELATIONSHIP – I.E. FATHER OR MOTHER – OR "N/A") SEE BACK ☐ SEE ATTATCHED ☐		
Diabetes:	High Blood Pressure:	Heart Disease:
Alcoholism:	Stroke:	Mental Illness:
Cancer:	Other:	

SIGNATURE	
Signature of Guardian:	Date:

By signing above you agree that the above information is true and correct. You authorize WVFP to leave a voicemail on the phone number(s) provided unless otherwise notated. Should there be any missing information, Western Valley Family Practice may refuse service. A No Show Fee of $20-$40 will be charged for all no show appointments. Also by signing this I acknowledge receipt of WVFP HIPAA Privacy Act Policy. This indicates we participate with Colorado Prescription Monitoring Program and Quality Health Network which is a centralized data base for healthcare professionals and authorize Rx prescription history consent. You are responsible for you balance; we will bill your insurance but if there is a deductible or co-pay it is due at time of service.