HAMILTON PEDIATRIC ASSOCIATES, P.C.
3 HAMILTON HEALTH PLACE
SUITE A
HAMILTON, NJ 08690
609-581-4480

Patient Intake Form

Patient Name: _____ ,_____ ,_____

FIRST *MIDDLE* *LAST*

Age_____ DOB_____ Race: _____ Ethnicity: _____
Home Address:_____City:_____
State:_____ Zip Code:_____ Social Security # _____-____-_____
Preferred Language: _____ Home Phone:_____

Mother's Name :_____ DOB:_____ _Social Security #_____-____-____
Marital Status: _____Mother's Employer_____
Business Phone: (_____)_____ Cell Phone (_____)_____
Occupation :_____ Insurance Company :_____
Policy Number_____ Group Number_____

Father's Name: _____ DOB:_____Social Security #_____-____-____
Marital Status: _____ Father's Employer:_____
Business Phone (_____)_____ Cell Phone: (_____)_____
Occupation: _____ Insurance Company_____
Policy Number_____ Group Number_____

ASSIGNMENT OF INSURANCE BENEFIT

I hereby authorize direct payment of medical benefits to HAMILTON PEDIATRIC ASSOCIATES, P.C.. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

INSURANCE CARDS MUST BE PRESENTED AT EACH VISIT.

Please list all family members or guardians who will have authority to discuss medical information.

1. _____ 2. _____

Patient or Parent Signature: X_____
Date: _____
(Must have signature in order to share medical information with additional family members)

HAMILTON PEDIATRIC ASSOCIATES, P.C.
3 HAMILTON HEALTH PLACE
SUITE A
HAMILTON, NJ 08690
609-581-4480

Medical History

Please fill out information as best as possible.

Problem List: _____
_____
_____
_____
_____

If child is sick list complaint_____

Family History:(*Please provide relationship, Health problems, & Status*)

Relationship	*Health Problems*	*Status*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:

Birth History:

Child's Birth Weight: _____lbs. _____oz.
Child's Discharge Weight: _____lbs. _____oz.
Child's Birth Length: _____ inches _____cm.
Child's Birth Head Circumference: _____ inches _____cm.
Mother's Blood Type: _____ RH type ☐ (+) ☐ (-)
Child's Blood Type: _____ RH type ☐ (+) ☐ (-) COOMBS ☐ (+) ☐ (-)
Was the Child breech at presentation? Yes ☐ *No* ☐
Did mother receive the Hep B vaccine? Yes ☐ *No* ☐
How was the Child delivered?
☐ *Forceps* ☐ *Vaginal* ☐ *Cesarean* ☐ *Vacuum* ☐ *Vac. & Forceps*

HAMILTON PEDIATRIC ASSOCIATES, P.C.
3 HAMILTON HEALTH PLACE
SUITE A
HAMILTON, NJ 08690
609-581-4480

APGAR =*A*ctivity and muscle tone, Pulse, Grimace Response, Appearance, Respiration
(If information is known, please fill out, if not leave blank. Test is normally done in Hospital at time of baby's birth.)

_____ *@ 1 Min* _____ *@ 5 Min* _____ *@ 10 Min (if done)*

Was the child circumcised? ☐ *Yes* ☐ *No*

Did the child pass a hearing test? ☐ *Passed* ☐ *Failed*

If failed which ear? ☐ *Right Ear* ☐ *Left Ear* ☐ *Both Ears*

Did the child get 1st Hep B vaccine in hospital? ☐ *Yes* ☐ *No When?*_____

What was the total gestation age in weeks? _____ *weeks.*

Did patient pass metabolic panel in hospital? ☐ *Yes* ☐ *No*

Past Surgical/Hospitalization History:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Who does the patient live with? _____

The patient lives in a? _____

Are there any family interval changes? ☐ *Yes* ☐ *No*

*If yes describe:*_____

*How many sisters*_____ *and/or brothers* _____ *does the patient have?*

What is the custody status if child has 2 households? _____

What kind of child care does the patient get? _____

Is the child exposed to any of the following and where?

☐ *Smoking*	☐ *Home*	☐ *Relatives house*	☐ *Babysitter*
☐ *Lead Paint*	☐ *Home*	☐ *Relatives house*	☐ *Babysitter*
☐ *Tuberculosis*	☐ *Home*	☐ *Relatives house*	☐ *Babysitter*
☐ *Drugs*	☐ *Home*	☐ *Relatives house*	☐ *Babysitter*
☐ *Pets*	☐ *Home*	☐ *Relatives house*	☐ *Babysitter*

HAMILTON PEDIATRIC ASSOCIATES, P.C.
3 HAMILTON HEALTH PLACE
SUITE A
HAMILTON, NJ 08690
609-581-4480

List all the subspecialist the patient has? (if any)

Doctor's Name *Specialty*

_____ _____
_____ _____

***Medications**: (Please list all medications prescribed currently taken along with strength and how it is taken.)*

(Medication) *(Strength)* *(How it's taken)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Vitamins/OTC's:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies:

*Allergy:*_____ *Reaction:*_____
_____ _____
_____ _____
_____ _____

Recent injuries or illness?

Date: _____ *Recent illness/injury :*_____
Date: _____ *Recent illness/injury:*_____

HAMILTON PEDIATRIC ASSOCIATES, P.C.
3 HAMILTON HEALTH PLACE
SUITE A
HAMILTON, NJ 08690
609-581-4480

FAMILY HISTORY

Are there any Risk factors for any of the following items in the family?

Risk of Hypertension? ☐ *Yes* ☐ *No If yes describe.*_____
Risk of visual impairment? ☐ *Yes* ☐ *No If yes describe.*_____
Hearing impairment? ☐ *Yes* ☐ *No If yes describe.*_____
Complaints of difficulty hearing? ☐ *Yes* ☐ *No If yes describe.*_____
Risk of Anemia? ☐ *Yes* ☐ *No If yes describe.*_____
Risk of Lead Poison? ☐ *Yes* ☐ *No If yes describe.*_____
Risk of TB ? ☐ *Yes* ☐ *No If yes describe.*_____
Risk of Hyperlipidemia? ☐ *Yes* ☐ *No If yes describe.*_____
Risk of Arrhythmia? ☐ *Yes* ☐ *No If yes describe.*_____
Risk of Diabetes? ☐ *Yes* ☐ *No If yes describe.*_____

PLEASE PROVIDE A COMPLETE COPY OF YOUR CHILD/CHILDREN'S IMMUNIZATION RECORDS