Date: _____

Miller Heights Medical Associates

Brian D. Kuronya D.O.

PEDIATRIC REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Nickname: _____

Date of Birth: _____ Social Security # _____

Sex: (circle one) Male/Female

Patient Street Address: _____

City, State, Zip: _____

Mailing/Billing Address: _____

City, State, Zip: _____

Mother's Name: _____ Email: _____

Home Phone: _____ Cell: _____

Father's Name: _____ Email: _____

Home Phone: _____ Cell: _____

How did you hear about Miller Heights Medical? _____

Interested in Patient Portal: **Yes or No**

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Policy # _____ Group # _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: _____ Social Security #: _____

Secondary Insurance Company Name: _____

Policy #: _____ Group # _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: _____ Social Security #: _____

PARENT/GUARDIAN INFORMATION

Mother's Information	Father's Information
Name:	**Name:**
Spouse's Name:	**Spouse's Name:**
Address: **City, State, Zip:**	**Address:** **City, State, Zip:**
Home Phone: **Cell Phone:**	**Home Phone:** **Cell Phone:**
Employer Name: **Can we contact work for an emergency: yes or no** **Work Phone #:**	**Employer Name:** **Can we contact work for an emergency: yes or no** **Work Phone #:**

In the event that you are not able to bring your child to an appointment please list all persons whom you give permission to be involved in your child's healthcare and as an emergency contact:

1) _____ Contact Phone #: _____
2) _____ Contact Phone #: _____
3) _____ Contact Phone #: _____
4) _____ Contact Phone #: _____
5) _____ Contact Phone #: _____

Parent/Guardian Name (Print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Miller Heights Medical Associates

Medical History

Patient Name: _____ Date of Birth: _____

Allergies to Medications/X-Rays, or Foods: Yes/No

(If yes please list name of medications/foods and type of reaction)

_____

_____

_____

Medications:

(Prescriptions, over-the-counter, vitamins, supplements, herbs, etc)

Name Dose

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Delivery Specifications:

Did the Mother have a full term delivery? _____

Was the delivery vaginal or C-Section: _____

Breast Feeding or Bottle Feeding? _____

Immunizations History:

Hepatitis B at Birth? Date: _____

Up to date on vaccines _____ Do you vaccinate? _____

Past Medical History: (Please list diagnoses such as any genetic birth defects, Childhood Cancers, or cardiac)

_____ _____

_____ _____

Hospitalizations: (What type of operation and month/year?)

Operations: _____ _____

_____ _____

Family History: (siblings, parents, grandparents and whether it is Maternal (mother) or Paternal (Father) side)

Illness	Family Member-Relation/Maternal or Paternal	Age	Circle One
Genetic Birth Defects	_____	_____	**Alive/Deceased**
	_____	_____	**Alive/Deceased**
	_____	_____	**Alive/Deceased**
Childhood Cancers	_____	_____	**Alive/Deceased**
	_____	_____	**Alive/Deceased**
	_____	_____	**Alive/Deceased**
Early Cardiac Deaths	_____	_____	**Alive/Deceased**
	_____	_____	**Alive/Deceased**
	_____	_____	**Alive/Deceased**

Patient Name (print): _____

Parent/Guardian Name (Print): _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____