MINOR/CHILD REGISTRATION

(PLEASE PRINT)

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Date_____

Home Phone_____

PATIENT INFORMATION

Name of Minor/Child_____
Last Name First Name Initial

Sex ☐ M ☐ F Age_____ Birthdate_____ Nickname_____ Hobbies_____

Home Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

Person financially responsible_____ Home Phone_____ Work Phone_____

Whom may we thank for referring you?_____

INSURANCE COVERAGE

Father's/Guardian's Name_____

Address (if different from patient's)_____

Home Phone_____ (if different from above) Work Phone_____ (if different from above)

Employer_____

Soc. Sec.#_____ Birthdate_____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name_____

Phone No._____

Address_____

Group#_____

Policy#_____

Mother's/Guardian's Name_____

Address (if different from patient's)_____

Home Phone_____ (if different from above) Work Phone_____ (if different from above)

Employer_____

Soc. Sec.#_____ Birthdate_____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name_____

Phone No._____

Address_____

Group#_____

Policy#_____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance Identification#_____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

FAMILY HISTORY

Has any member of the family or close relative had:

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Mental Disorders
☐	☐	Asthma or Hay Fever	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Hemophilia – Bleeder	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Other_____
☐	☐	Convulsion or Epilepsy	☐	☐	Kidney Disease			

(OVER)

BIRTH HISTORY

Hospital _____ Obstetrician _____

Type of delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Weight _____

Did baby have any problems at or immediately after birth? _____

List Age Cooed or laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toilet Trained _____

HEALTH HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Has your child been hospitalized?	☐	☐

Medications _____

Date Reason Hospital

Allergies _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Chicken Pox	☐	☐	Heart Problems	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Constipation, Diarrhea	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Kidney Disease	☐	☐	Speech Problems
☐	☐	Bed Wetting	☐	☐	Diabetes	☐	☐	Lead Poisoning	☐	☐	Thyroid Disease
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Measles	☐	☐	Urinary Diseases
☐	☐	Bleeding, excessive	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Cancer	☐	☐	Fainting	☐	☐	Mumps	☐	☐	Worms
☐	☐	Cerebral Palsy	☐	☐	Hearing Problems	☐	☐	Pneumonia	☐	☐	Other

IMMUNIZATIONS

Check (✔) whether or not your minor/child has been given the following immunizations. If yes, please fill in the date given.

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
☐	☐	_____	DPT Series of 3 Shots	☐	☐	_____	Polio by Mouth, Series of 3	☐	☐	_____	Diphtheria Tetanus
☐	☐	_____	DPT Booster Shots	☐	☐	_____	Measles Vaccine	☐	☐	_____	Hepatitis B
☐	☐	_____	Polio Shots Series of 3	☐	☐	_____	Mumps Vaccine	☐	☐	_____	Tuberculin Test
☐	☐	_____	Polio Booster Shots	☐	☐	_____	Rubella Vaccine				Result _____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Parent/Guardian Date

#13238 Medical Arts Press 1-800-328-2179