Pediatric & Adolescent Medicine

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New Patient Information

Dixit MD LLC
Dr. Manish Dixit M.D., F.A.A.P.

Child Information

Name[Last]__________[First]________________[M.I.]__________[Birthdate]__________[SSN]______________M/F

Mailing Address________________________________City______________________State________Zip___________

Home Phone #________________________________E-Mail Address______________________________________

Preferred Pharmacy____________________________Child's School (If Applicable)__________________________

Parent's Information (Mother, Father, or Legal Guardian) - REQUIRED

Mother's Name____Employer______________________________
Address______________________________________City______________________State________Zip__________
Home Phone_____________________Work Phone____________________________Cell______________________
Date of birth___________________________SSN__________________________________

Father's Name____Employer______________________________
Address______________________________________City______________________State________Zip__________
Home Phone_____________________Work Phone____________________________Cell______________________
Date of birth___________________________SSN__________________________________

Notify in case of Emergency other than parent's [Name]____
[Phone]____

Insurance Information
Name of Insurance Company____
Insurance Company address____
Policy Holder Name____
Policy Holder Address_______________________________________DOB______________Phone______________
Policy Holder Employer____
Policy # ______________________________________Group #________________________________

This is a direct assignment of my rights and benefits under this policy. This payment will note exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A photocopy of this agreement shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
I have received a copy of HIPPA (Health Insurance Portability and Privacy Act) and agree to the policy.

Date on_________________________ At_____Dr. Dixit's Office_______

_______________________________________ _______________________________________
Signature of Guarantor/Guardian Witness

Patient Name:____DOB:______________________________

This form will be filled out by the parent/guardian

Relationship to patient:_________________________________

Previous clinic/doctors:____

Family Profile

Number of persons living in the house:

Mother______Father_______Brother(s)______Sister(s)_______Grandparent(s) __

Step-parent(s)______Guardian(s):________ Others:___________________________________

Occupation of parent(s)/guardian(s) ____

Sibling's Names (Age):____

____

____

Past Medical History

General Health:____

List allergies to foods/animals/pollen:____

List allergies or bad reactions to any medications:_________________________________

Birth: Premature/Birth weight_________________ Full term/Birth weight_________________

Any newborn problems (breathing/antibiotics/heart problems)____________________________

____

List all surgeries:____

____

List all recurring illnesses:____

____

List serious illnesses/accidents that required overnight hospitalization:______________

____

List all medications being taken (prescribed or over the counter):___________________

____

Any sickle cell disease or sickle trait? Any transfusions, etc?_______________________

Any anemia (low blood)?____

List other significant medical/emotional problems:__________________________________

____

Patient Name:_______________________________________DOB:_____________________________

Immunizations

Do you have this child's immunization record?	No____	Yes____
Are the immunizations up to date?	No____	Yes____
Ever have a temp more than 102, a screaming fit convulsions after an immunization?	No____	Yes____
Ever have a positive reaction to a TB skin test?	No____	Yes____

Please provide a copy of immunization record with paperwork

Family Health: (Patient's brothers/sisters, parents, grandparents, or other relatives)

Do any family members have a history of:

Alcoholism/substance abuse	No____	Yes____
Allergy/asthma	No____	Yes____
Birth defects	No____	Yes____
Blood problems	No____	Yes____
Cancer	No____	Yes____
Diabetes	No____	Yes____
Heart problems	No____	Yes____
High blood pressure	No____	Yes____
High cholesterol	No____	Yes____
Mental/emotional problems	No____	Yes____
Migraines	No____	Yes____
Seizures/epilepsy	No____	Yes____
Sickle cell problems	No____	Yes____
Stroke	No____	Yes____
Tuberculosis/aids	No____	Yes____

Other:____

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Parent/Guardian preference regarding communication of health information
CONSENT TO TREAT

I hereby give permission for the following people to obtain medical care for my child:

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please initial here if you wish to not give permission for additional family members, relatives, or close personal friends to obtain medical care for your child in your absence or have access to any information regarding your child's medical condition(s).

__________________________ Signature of parent/guardian

______________ Date