



NEW PATIENT INFORMATION

Buckeye Pediatrics, LLC
Sundance Business Center ~ 23374 W. Yuma Road, Suite 101 Buckeye, AZ 85326 ~ 623-374-7833
www.buckeyepeds.com

First Name: _____ MI: _____ Last Name: _____ Male / Female (Please Circle)
Date of Birth: _____ Social Security #: _____

Mother/Guardian

Name: _____
Address: _____ Home Phone: _____
Employer Name: _____ Employer Address: _____
Work Phone: _____ Social Security #: _____ Date of Birth: _____
Email: _____

Father/Guardian

Name: _____
Address: _____ Home Phone: _____
Employer Name: _____ Employer Address: _____
Work Phone: _____ Social Security #: _____ Date of Birth: _____
Email: _____

Insurance Information

Who is the policyholder of the Insurance? MOTHER / FATHER (Please Circle)
Insurance Company: _____ Policy Number: _____
Group Number: _____ Insured: _____

Emergency Information

Person to Contact: _____ Relationship: _____
Address: _____ Phone: _____

Referral Information

Whom may we thank for this referral?
Name: _____ Address: _____

Patient Responsibility Statement and Medical Release Information

I/we, the undersigned, understand that we are responsible for any unpaid balance on this account. Buckeye Pediatrics, LLC will file the necessary insurance claims, excluding secondary insurance claims, but I/we understand that we are responsible for any balance left unpaid after 120 days of the date of service. Failure to satisfy this obligation may cause the entire balance to be placed with a collection agency or attorney. I/we will be responsible for any charges incurred for collecting this debt; this includes, but is not limited to, collection fees, credit bureau fees, and any legal expense. I hereby authorize you to release any and all information which you may possess relating to my examination and illnesses. I understand I may revoke this consent in writing at any time.

Signed: _____ Date: _____
Relationship (if other than patient): _____

Family History

Circle all diseases below that have occurred in this child's brothers, sisters, parents, grandparents, aunts, uncles, or first cousins. Please specify who (in relationship to the child) in the space next to the illness and their approximate age at diagnosis.

Asthma _____	High Blood Pressure _____	Anemia _____
Sinus Allergies _____	High Cholesterol _____	Bleeding Disorder _____
Eczema _____	Heart Attack / Stroke _____	Anesthesia Reactions _____
Cystic Fibrosis _____	Diabetes _____	Depression / Anxiety _____
Birth Defects _____	Kidney Problems _____	Substance Abuse _____
Seizures _____	Digestive Problems _____	Cancer (specify type) _____
ADHD _____	Liver problems _____	Other _____

Birth History

Did mother receive prenatal care? Yes / No

Was baby born full term(37-42 weeks)? Yes / No (If preemie, how early?) _____

Was it a vaginal delivery? Yes / No (If c-section, state reason) _____

Did mom have any problems or complications during this pregnancy? Yes / No

Diabetes, high blood pressure, preeclampsia, preterm labor, other? _____

Did mom have any of the following infections during this pregnancy? Yes / No

Yeast, herpes, gonorrhea, chlamydia, syphilis, HIV, urinary tract infection? _____

Did mom test positive for group B strep (GBS) during this or a previous pregnancy? Yes / No

If yes, did she receive antibiotics during labor? Yes / No / Don't know

What was baby's birth weight? _____ Mom's blood type? _____

Did baby have any problems in the newborn nursery before hospital discharge? Yes / No

Jaundice, low blood sugar, feeding problems, breathing problems or needed oxygen, heart murmur, suspicion of infection, sepsis, pneumonia, other? _____

Name of birth hospital? _____ How long did he/she stay? _____

Did he/she have to go to the NICU or special intensive care unit for newborns? Yes / No

Was baby at least 48 hours old when the newborn metabolic screen (PKU) was done? Yes / No

Did he/she pass the newborn hearing screen with both ears? Yes / No

Past Medical History

(Please explain any "Yes" answers)

Any hospitalizations? Yes / No _____

Any surgeries? Yes / No _____

Any serious injuries, concussions, or broken bones? Yes / No _____

Taking any medications, vitamins, herbals, or fluoride? Yes / No _____

Any allergies to medications? Yes / No _____

Any allergies to foods? Yes / No _____

Any reactions to any immunizations? Yes / No _____

Any chronic cough or recurrent wheezing or pneumonia? Yes / No _____

Ever diagnosed with asthma or reactive airway disease? Yes / No _____

Any nasal or sinus allergies? Yes / No _____

Any eczema or skin problems? Yes / No _____

Any vision or hearing impairments? Yes / No _____

History of frequent ear infections? Yes / No _____

Any heart problems or heart murmur? Yes / No _____

Any stomach or digestive problems? Yes / No _____

Any kidney or urinary tract problems? Yes / No _____

Any seizures, tics, or migraines? Yes / No _____

Any developmental delays or learning disabilities? Yes / No _____

Any severe behavioral problems or psychiatric illness? Yes / No _____