ELGIN FAMILY PHYSICIANS CHILD (Ages 0-17) REGISTRATION FORM TODAY'S DATE:_____

Welcome to Elgin Family Physicians. Thank You for completing the entire Patient Registration Form.

REGISTRATION DATA PLEASE PRINT

Date of Birth ____/_____/_____ Gender: ☐ Male ☐ Female Religion: _____

Last Name: _____ First Name:_____ MI:_____

Address:_____

Race: _____ Ethnicity: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Fathers Last Name: _____ First Name: _____ Date of Birth ____/_____/_____

Mothers Last Name: _____ First Name: _____ Daye of Birth ____/_____/_____

Are the parents married? ☐ Yes ☐ No Do they live together? ☐ Yes ☐ No

Who is the Guarantor of the Patient? ☐ Father ☐ Mother ☐ Other:_____

Guarantors SSN: _____ Guarantors Employer:_____

Address if Different than Patient: _____

Phones: Home _____ Work _____ Ext:_____ Cell: _____

Which Phone is the best to Contact Guarantor? ☐ Home ☐ Work ☐ Cell Email Address: _____

Emergency Contact: _____ Relationship to Patient_____

Their Phone: Home _____ Work: _____ Ext:_____ Cell: _____

Best Contact Number: ☐ Home ☐ Work ☐ Cell

Referred by/How Did You Hear About Us: _____

Medical insurance Information:	**Insurance Company**	**Policy Number**	**Policy Holder**	**DOB**
Primary:				
Secondary:				

MEDICAL HISTORY

MEDICATIONS: **List all Medications child takes, including over the counter medications:**

Medication	Dosage	Frequency	Medication	Dosage	Frequency

ALLERGIES: **List all medications to which the child is allergic including food and seasonal allergies:**

_____ _____ _____ _____ _____

HOSPITALIZATIONS: **List all hospitalizations, injuries and operations**

Year	**Illness, Injury or Operation**	**Hospital**	**City & State**

PERSONAL HEALTH HISTORY: **Check all the items below that apply to the child**

☐ Alcoholism	☐ Anemia	☐ Asthma	☐ Auto Immune Disease	☐ Bladder Issues
☐ Cancer Type_____	☐ Chickenpox	☐ Diabetes	☐ Depression	☐ Drug Abuse
☐ High Blood Pressure	☐ Epilepsy	☐ Glaucoma	☐ Hepatitis	☐ Heart Disease
☐ Kidney Disease	☐ Liver Disease	☐ Obesity	☐ Osteoarthritis	☐ Lung Disease
☐ Mental Illness	☐ Phlebitis	☐ Ulcer	☐ Rheumatic Fever	☐ Stroke
☐ Rheumatologic Condition		☐ Suicide Attempt	☐ Thyroid Disease	☐ Uncontrolled Bleeding
☐ Sexually Transmitted Diseases		☐ Other: _____		

FOR CHILDREN 13 and Over

HABITS: Does the child Smoke? ☐ Never Smoked ☐ Former Smoker? How Long Ago Did He/She Quit? _____

☐ Current Smoker? How Many Packs Per Day? _____ Interested in Quitting? ☐ Yes ☐ No

Does the child drink? ☐ Yes ☐ No If Yes How many Ounces per day? _____ How Many Times Per Month? _____

Has the child ever taken Recreational Drugs? ☐ Yes ☐ No If yes: What?_____ When? _____

PLEASE COMPLETE REVERSE SIDE

FAMILY HEALTH HISTORY

	First Name	Year of Birth	Health is: Good	Poor	Died at Age	Cause of Death	Current Medical Problems
Father	_____	_____	☐	☐	_____	_____	_____
Mother	_____	_____	☐	☐	_____	_____	_____
Brothers	_____	_____	☐	☐	_____	_____	_____
	_____	_____	☐	☐	_____	_____	_____
	_____	_____	☐	☐	_____	_____	_____
Sisters	_____	_____	☐	☐	_____	_____	_____
	_____	_____	☐	☐	_____	_____	_____
	_____	_____	☐	☐	_____	_____	_____
Child's Father's Father		_____	☐	☐	_____	_____	_____
Child's Father's Mother		_____	☐	☐	_____	_____	_____
Child's Mother's Father		_____	☐	☐	_____	_____	_____
Child's Mother's Mother		_____	☐	☐	_____	_____	_____

FAMILY HEALTH HISTORY: Check all the items below that apply to the child's family

☐ Alcoholism	☐ Anemia	☐ Asthma	☐ Auto Immune Disease	☐ Bladder Issues
☐ Cancer Type_____	☐ Diabetes	☐ Depression	☐ Drug Abuse	☐ High Blood Pressure
☐ Epilepsy	☐ Glaucoma	☐ Hepatitis	☐ Heart Disease	☐ Kidney Disease
☐ Liver Disease	☐ Obesity	☐ Osteoarthritis	☐ Lung Disease	☐ Mental Illness
☐ Phlebitis	☐ Ulcer	☐ Rheumatic Fever	☐ Stroke	☐ Rheumatologic Condition
☐ Suicide Attempt	☐ Thyroid Disease	☐ Uncontrolled Bleeding		

☐ Other: _____

HEALTH CARE PROVIDERS: **Who has the child seen for his/her health care needs in the past five Years?**

Name of Doctor or other Providers **Primary Problems Cared For**

_____ _____

_____ _____

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: **I authorize the release of any medical records or medical and financial information, of my child, necessary to process any medical claims for services provided to the above named patient. In addition, I authorize payment of medical benefits to Elgin Family Physicians, SC for medical services provided to my child. I understand that my child's insurance may not cover all the costs for medical services provided by Elgin Family Physicians. As such, I agree to assume full financial responsibility for any portions not covered.**

SIGNED _____ **Date** _____

PRINTED NAME_____

RELATIONSHIP TO PATIENT:_____