North Olympic Healthcare NETWORK

North Olympic Healthcare Network
240 West Front Street | Suite A
Port Angeles, WA 98362-2609
(360) 452-7891 P | (360) 452-8087 F

NEW PATIENT REGISTRATION – CHILD (0-18YRS)

CHILD INFORMATION

First Name _____

Last Name _____

Gender Male ☐ Female ☐ Date of Birth _____

Child Social Security Number _____

PRIMARY INFORMATION (where and whom the child lives with)

Parent/Guardian Name _____

Child lives with: *Both Parents ☐ Mother ☐ Father ☐ Foster Parents ☐ Grandparents ☐ Legal Guardian ☐ Emancipated Minor ☐ Other* _____

Child's Home Address _____

_____

Mailing Address (if different than above) _____

_____

Contact Phone # _____Email Address _____

EMERGENCY CONTACT INFORMATION

Contact Name _____

Contact Phone # _____ Relationship _____

PATIENT NAME _____DATE OF BIRTH _____

FEES AND BILLING
No patient will be denied service due to inability to pay. We offer a Sliding Fee Discount program which can provide discount fees for certain services. To see if you qualify please complete the information below.

Gross Monthly Household Income $ _____
Number of Family Members in Your Household _____
I decline to see if I qualify for Sliding Fee Discount ☐

ASSISTANCE
Does the patient need a language interpreter for appointments**?** ☐ Yes ☐ No
Does the patient need a sign language interpreter for appointments? ☐ Yes ☐ No
Does the patient need transportation assistance for appointments? ☐ Yes ☐ No

INSURANCE INFORMATION

Does the child have health insurance? Yes ☐ No ☐
If no, would you like information on signing up for health insurance? Yes ☐ No☐

Insurance Name _____

Policy Number _____ ___Group # _____

Subscriber Name _____Subscriber Date of Birth _____

Subscriber relationship to child _____

Is there a secondary insurance? Yes ☐ No ☐

Insurance Name _____

Policy Number _____Group Number _____

Subscriber Name _____Subscriber Date of Birth _____

Subscriber relationship to child _____

North Olympic Healthcare NETWORK

NORTH OLYMPIC HEALTHCAR NETWORK
PEDIATRIC HEALTH QUESTIONNAIRE

DATE**:** _____ NAME (PRINT): _____

DATE OF BIRTH: _____ AGE: _____ **GENDER**: ☐ **M** ☐ **F** **SEX AT BIRTH:** ☐ **M** ☐ **F**

BIRTH HISTORY

1. Birthplace _____
2. Normal Pregnancy ☐ Yes ☐ No
3. Normal Delivery ☐ Yes ☐ No
4. Was baby full-term? ☐ Yes ☐ No

GROWTH AND DEVELOPMENT

1. Any development concerns? _____
   _____
2. Number of years in school: _____
3. Attends special school or classes? ☐ Yes ☐ No
4. Discipline or behavior problems? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

PAST MEDICAL HISTORY

1. Please mark any of the listed major medical problems you child has: ☐ Asthma ☐ Allergies
   ☐ Depression ☐ Anxiety ☐ Diabetes ☐ Seizures ☐ Other _____
2. Please list any serious injuries your child has had: _____
   _____
3. Has your child had chicken pox? ☐ Yes ☐ No If yes, what age? _____
4. Had you child had any other contagious diseases (i.e.) measles, mumps, etc.? ☐ Yes ☐ No
   If yes, please list: _____
5. Immunizations (Shots)
   Please attach a vaccine history if available

MEDICATIONS

1. Please list all medications your child is currently taking: _____
   _____

HOSPITALIZATIONS

1. Please list any hospitalizations your child has had (when, where and why): _____
   _____
   _____

ALLERGIC REACTIONS

1. Does your child suffer from any allergic reactions (Drugs, Asthma, Hives, Eczema, Hay Fever, etc.)?
   _____

SOCIAL HISTORY

- Father's Age: _____ Health: ☐ Good ☐ Fair ☐ Poor ☐ Father is deceased
- Mother' Age: _____ Health: ☐ Good ☐ Fair ☐ Poor ☐ Mother is deceased
- Number of siblings: _____ Ages: _____
- Who has legal custody of the child? _____

FAMILY HISTORY

1. Please mark any history in the family of the following diseases: ☐ Diabetes ☐ Heart Disease
   ☐ Cancer ☐ TB ☐ Convulsions ☐ Seizures ☐ Allergies ☐ Other _____

PLEASE TURN OVER AND COMPLETE

North Olympic Healthcare NETWORK

GENERAL

1. Is your child having currently having any specific issues or problems? ☐ Yes ☐ No
   If yes, please list here: _____
   _____

ANY SPECIAL COMMENTS ABOUT YOUR CHILD

_____
_____
_____
_____

CHILD'S LAST DOCTOR

Please list your child's last doctor: _____

Who completed this form? _____

Relationship to child? _____