TriStar Medical Group StoneCrest Family Physicians

Responsible Party	
Name	
Address	
Phone	
Birth Date	
Social Security Number	
Patient Information	
Name	
Address	
Phone	
Cell Phone	
Email Address	
Birth Date	
Sex	
Marital Status	
Age	
Social Security #	
Emergency Name	
Emergency Phone	

Section must be completed:

1) **Race:** ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Unreported/Refused to Report
2) **Ethnicity (Cultural Background):** ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report
3) **Language:** ❑ English; ❑ Spanish; ❑ Indian; ❑ Japanese; ❑ Chinese; ❑ Korean; ❑ French; ❑ German; ❑ Russian; ❑ Other _____________

Health Insurance	
Name of Insured	
Patient Relationship to Insured	
Birth Date	
Primary Insurance Company	
Primary Claim Address	
Primary Phone	
Primary Policyholder	
Primary Subscriber #	
Primary Group #	
Primary Insurance Copay	
Specialty Insurance Copay	
Secondary Insurance Company	
Secondary Subscriber #	
Secondary Group #	
Pharmacy Name	
Pharmacy Phone#	

How did you hear about us?

❑ Referring Provider ❑ Website ❑ HealthGrades.com ❑ Family/Friends ❑ Blog
❑ Search Engine ❑ Facebook ❑ Yelp.com ❑ Physician Directory ❑ Twitter
❑ Google Places Page ❑ Vitals.com ❑ Other

I certify the above demographic and insurance information listed above to be correct. I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim.

X	Date

Name ____ DOB ___________

Child's Birth History

Was the child born premature? __________ If so, how early? ___________ Was the child required to stay in intensive care unit? ______

If so, how long? __________ Was the child delivered by C-section? __________

If so, what was the reason?

Authorization of Treatment

Medical care and immunizations cannot be given unless my child is accompanied by one of the following:

____

Past Medical History

Has your child ever been in the hospital? __________ If so, why? ____

Has your child ever had surgery? __________ If so, what kind? ____

Please indicate if your chils has had any of the following conditions (circle):

Diabetes	High blood pressure	Heart disease	Lung disease
Kidney disease	Seizures	Asthma	Measles
Tuberculosis	Mumps	Chicken Pox	Urinary tract infection
Cancer	Other (please specify): ______________________		

Medications/Allergies

Please list any medications that your child is currently taking (prescription or over-the-counter): ________________________

____

Is your child allergic to any medications? __________ If so, please list them: ______________________________________

____

Immunizations

Is your child up to date on his/her immunizations? __________ (Please provide us with a copy of your child's immunization record)

Family Medical History

Please indicate if your child has any blood relatives with the following conditions (circle):

Diabetes	High blood pressure	Heart disease	Lung disease
Kidney disease	Seizures	Asthma	Cancer

Other (please specify): ____

Please list the names and ages of the child's brothers and sisters:

Name	Age
____________________________________	________________
____________________________________	________________
____________________________________	________________
____________________________________	________________

Social History

Who does the child live with?

Does anybody at home smoke? __________ If so, who? ____

What school/day care does your child attend? ____

Does your child have any special interests/hobbies? __________ If so, what are they?______________________________

Please give any information not asked above that you believe is important:______________________________

____

Parent/Guardian Signature ________________________________ Date: ____________________