TRISTAR MEDICAL GROUP 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: _____

Thank you for choosing our office!

How did you hear about us? ***please circle***

Word Of Mouth / Friend and Family

Insurance

Physician Referral _____

Signage

Minute Clinic located @ _____

Care Spot located @ _____

The Little Clinic located @ _____

Advertising

Online / Internet _____

Other _____

Patient Name: _____

Date of Birth: _____/_____/_____