Dover Pediatrics, PLLC ***Today's* Date**: _____

_____ _____ _____

Patient's First Name **Last Name** **Date of Birth**

Your Pharmacy:_____City:_____State_____

Race: □ White-Caucasian □ American Indian/Alaskan □ Asian □ Black/African American □ Hawaiian □ Hispanic/Latino/Spanish Origin □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer not to answer

Language(s) Spoken at home: □ English □ Other: _____ **Do you need an language Interpreter?** □ Yes □ No

The following information will be entered into your child's electronic health form. **Email Address:** _____@_____

Contact Preference(s): □ Home Phone: _____ □ Cell Phone: _____ □ Text: _____

Child's current medications:		

Please review the following medical conditions and list those applicable to your child or your child's family members:

Medical Condition	Patient Yes	Patient No	Mother's Family Yes	Mother's Family No	Father's Family Yes	Father's Family No
Seizures	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□
Allergies: ***Seasonal***	□	□	□	□	□	□
Food	□	□	□	□	□	□
Drug	□	□	□	□	□	□
Asthma	□	□	□	□	□	□
Blood Disorders: ***Anemia***	□	□	□	□	□	□
Bleeding Problems	□	□	□	□	□	□
Chronic Infections: ***Hep B***	□	□	□	□	□	□
Hep C	□	□	□	□	□	□
HIV	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Depression/Anxiety	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Hearing Problems	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□
Learning Problems	□	□	□	□	□	□
Congenital Malformations	□	□	□	□	□	□
Substance Abuse	□	□	□	□	□	□
Other- please explain:	□	□	□	□	□	□
Has your child ever seen a dentist?	□	□	If yes, *date* of child's last dental visit:		_____	
Has your child ever had surgery?	□	□	*Please list:*			
Has anyone in your family worried about affording groceries in the past twelve (12) months?	□	□				
Are there any smokers in your child's home?	□	□	*If yes, how many?*		□ *Inside Smokers* □ *Outside Smokers only*	

Mother's Name: _____DOB: _____ Occupation: _____

Father's Name: _____DOB: _____ Occupation: _____

Sibling's Name: _____DOB: _____ Occupation: _____

Sibling's Name: _____DOB: _____ Occupation: _____

Sibling's Name: _____DOB: _____ Occupation: _____

Sibling's Name: _____DOB: _____ Occupation: _____

Does your child live with you Monday through Sunday? □ Yes □ No - If parents aren't together, what is the custody and visitation arrangement?

_____

List all people living with your child in their home(s):_____

_____