

Alzein Pediatrics welcomes you!

Tell us about the patient! Don't worry, we'll get to know whether he/she loves veggies later!

INFORM	$ATI \cap NI$			ATICNIT
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Today's date: Patient's	birth date:		Patient's SS	SN:			
Patient's Name:	<u>M</u> I					_	
First		Last					
Patient's Address:Address		City		State	 Zip		
Hospital patient was born in (name, city a	nd state):						
Birth weight: Gestational	age:	_ Birth len	gth:		Sex:	M F	
Does patient currently have siblings at Alz	ein Pediatrics as	patients? \	ES NO				
Alright! Now it's the adult's turn							
Allight: Now it's the addit's turn	INI	FORMATIC	N ABOUT T	THE DAG	DENIT / C		
Makhawa Nama		FORMATIC	N ABOUT I	NE PAI	KENI/C	JUARDIAI	4
Mother's Name: First	MI	Last				_	
Mother's SSN:	Mother's cell: _		Mothe	r's DOB:			
Father's Name:						_	
First	MI	Last	= 4 1	DOD			
Father's SSN:	Father's cell:		Father's	s DOB: _			
Emergency contact:		R	elationship to	patient	:		_
Emergency contact phone number:		_					
Email address (gets you access to your page 1	atient portal!):						
			and finallyir			_)
INFORMATION ABOUT THE RESPONS	IBLE PARTY				\		
Primary insurance company name:							
Cardholder's name:		Cardhold	er's phone n	umber: ₋			
Insurance ID#:		Group#:					_
Secondary insurance company name:							
Cardholder's name:		Cardhold	er's phone n	umber: ₋			
Insurance ID#:		Group#:					_



We ask these questions so we can create a better, more intimate level of service for you!

OTHER RELEVANT QUESTIONS FOR YA!

Race [] American Indian or Alaska Native [] Asian [] Hispanic [] Polish [] Other	[] African American [] Native Hawaiian or Pacific Islander [] Arabic [] White
Languages spoken at home [] English [] Indian dialect [] Polish	[] Spanish [] Arabic [] Other
WE'RE MAKING YOUR LIFE EASIER ALRE	EADY!
Please identify the nearest pharmacy you wa your child is on his/her way to feeling better!	nt medication called into. This way, once you leave the office,
Pharmacy / Grocery store name:	Phone:
Important!! Our lawyers made us	
include this statementbut it helps ensure the best care for your child!! I authorize the treatment of my child by a Pro any information concerning my (or my child's)	vider employed by Alzein Pediatrics. I authorize the release of healthcare, advice, and treatment provided for the purpose of
include this statementbut it helps ensure the best care for your child!! I authorize the treatment of my child by a Proany information concerning my (or my child's evaluation and administering claims for insura	healthcare, advice, and treatment provided for the purpose of ance benefits. I also hereby authorize payment of insurance he Provider, realizing I am responsible to pay non-covered
include this statementbut it helps ensure the best care for your child!! I authorize the treatment of my child by a Pro any information concerning my (or my child's evaluation and administering claims for insurabenefits otherwise payable to me directly to the	healthcare, advice, and treatment provided for the purpose of ance benefits. I also hereby authorize payment of insurance he Provider, realizing I am responsible to pay non-covered I fee policies of Alzein Pediatrics.





Patient Name:	DOB:
ralient name.	DOB.

MEDICAL HISTORY / EVENTS ABOUT YOUR CHILD

	YES	NO
Prematurity		
Apnea		
Congenital problems		
Heart problems		
Asthma		
Arthritis		
Cancer		
Chemical dependency		
Convulsion / epilepsy		
Diabetes		
Heart disease		
Hemophilia (bleeding)		
High blood pressure		
Kidney disease		
Mental disorder		
Migraines		
Sickle cell		
Tuberculosis		
Cutest kid in the world (officially of course!)		
Other		