

Database Newborn - 15 years

Social Security Number _____ - _____ - _____
Name _____ Sex _____ Date of Birth _____ Age _____
Address _____ City _____ Zip _____
Phone (_____) _____ Parents Name _____ Parents Phone (_____) _____
Billing Party _____ Date of Birth _____ Social Security # _____
Place of Employment _____
Address _____ City _____ Zip _____

1. Age of Parents a. Mother _____ b. Father _____

No Yes Describe

- 2. Has the child had any serious illnesses or injuries? _____
- 3. Has this child had any developmental or neurological problems? _____
- 4. Has social behavior been a problem at school or home? _____
- 5. Has this child had any surgery? _____
- 6. Other physicians that this child has consulted. _____
- 7. Is there any medication to which the child is allergic or cannot take? _____
- 8. Is this child taking medication on a regular basis? _____

School which student attends _____

Grade Level of student _____

Height _____ Weight _____

We would like as complete a record of your child's immunizations as possible. Please complete the questions below by month and year as best you can without guessing.

Date of last Sabin Tri Polio _____

Date of last Tetanus Immunization _____

Date of MMR₁ _____ MMR₂ _____ or date child had Measles _____

Date of HIB Vaccine _____

Date of Hepatitis B Vaccine _____

Date of most recent Tuberculin Test _____

The above information is true to the best of my knowledge

Signature _____

Date _____