



NEW PATIENT CONSULTATION FORM

(Please complete and bring with you to your consultation.)

This information will be kept in our files for office use only. If you choose our doctors as your primary care physicians, this information will become part of your child(ren)'s permanent record. (Please print.)

Today's Date: _____

Name: _____
Father's Last Name First Name Middle Initial

Name: _____
Mother's Last Name First Name Middle Initial

Child(ren)'s *(please list name(s), age and gender):*

Whom may we thank for referring you to our practice? _____

Do we have your permission to use your name in our "thank you" correspondence? Yes No *(Circle one.)*

Any family history (children, parents, grandparents, siblings, aunts or uncles) of:
(please check appropriate items)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Early Heart Attacks | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Fatality From Illness | <input type="checkbox"/> Mental Problems |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> Interrupted Pregnancies | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |

----- FOR OFFICE USE ONLY -----

Doctor Notes:

