CHILDREN'S CLINIC & ASSOCIATES
MANU BHARGAVA, M.D.

PATIENT INFORMATION

Name of Minor/Child ______ Last Name ______ First Name ______ Initial

Sex ☐ M ☐ F Age ______ Birthdate ______ Nickname ______ Hobbies ______

Home Address ______ Street ______ City ______ State ______ Zip

Mailing Address ______ Street ______ City ______ State ______ Zip

Person financially responsible ______ Home Phone ______ Work Phone ______

Whom may we thank for referring you? ______

INSURANCE COVERAGE

Father's / Guardian's Name ______

Address (if different from patient's) ______

______

Home Phone ______ (if different from above) Work Phone ______ (if different from above)

Employer ______

Soc. Sec.# ______ Birthdate ______

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______

Phone No. ______

Address ______

______

Group# ______

Policy# ______

Mother's / Guardian's Name ______

Address (if different from patient's) ______

______

Home Phone ______ (if different from above) Work Phone ______ (if different from above)

Employer ______

Soc. Sec.# ______ Birthdate ______

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______

Phone No. ______

Address ______

______

Group# ______

Policy# ______

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance Identification# ______

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name ______ Relationship ______ Phone ______

Name ______ Relationship ______ Phone ______

FAMILY HISTORY

Has any member of the family or close relative had:

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Mental Disorders
☐	☐	Asthma or Hay Fever	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Hemophilia – Bleeder	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Other ______
☐	☐	Convulsion or Epilepsy	☐	☐	Kidney Disease			______

(OVER)

BIRTH HISTORY

Hospital__________ Obstetrician__________

Type of delivery__________ Complications__________

Birth Weight__________ Birth Length__________ Discharge Weight__________

Did baby have any problems at or immediately after birth?__________

List Age Cooed or laughed______ Sat______ First Word______ Held Head Up______ Walked______ Toilet Trained______

HEALTH HISTORY

Minor/Child's Physician__________ City/State__________ Phone__________

Date of last physical examination__________ Results__________

	YES	NO
Is Minor/Child under care of physician now?__________	☐	☐
Receiving any medication or drugs?__________	☐	☐
Has your child been hospitalized?__________	☐	☐

Medications__________

Date Reason Hospital

____

Allergies__________

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Chicken Pox	☐	☐	Heart Problems	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Constipation, Diarrhea	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Kidney Disease	☐	☐	Speech Problems
☐	☐	Bed Wetting	☐	☐	Diabetes	☐	☐	Lead Poisoning	☐	☐	Thyroid Disease
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Measles	☐	☐	Urinary Diseases
☐	☐	Bleeding, excessive	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Cancer	☐	☐	Fainting	☐	☐	Mumps	☐	☐	Worms
☐	☐	Cerebral Palsy	☐	☐	Hearing Problems	☐	☐	Pneumonia	☐	☐	Other

IMMUNIZATIONS

Check (✔) whether or not your minor/child has been given the following immunizations. If yes, please fill in the date given.

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
☐	☐	______	DPT Series of 3 shots	☐	☐	______	Polio by mouth, series of 3	☐	☐	______	Diphtheria Tetanus
☐	☐	______	DPT Booster shots	☐	☐	______	Measles Vaccine	☐	☐	______	Tuberculin Test
☐	☐	______	Polio Shots series of 3	☐	☐	______	Mumps Vaccine				Result______
☐	☐	______	Polio Booster Shots	☐	☐	______	Rubella Vaccine				______

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with__________
Name of Insurance Company(ies)

and assign directly to Dr. **MANU BHARGAVA, M.D.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

__________ __________
Signature of Parent/Guardian Date