Premier Pediatrics of Louisiana
325 W. 8th Street • DeRidder, LA 70634
Phone (337) 221-3075 • Fax (337) 221-3076
www.premierpediatricsla.net

NEW PATIENT INFORMATION

PATIENT INFORMATION

Today's Date _____/_____/_____

Last Name: _____ First Name: _____ M. I. : ____

Date of Birth: (MM/DD/YYYY) _____/_____/_____ Social Security #: _____-_____-_____

Sex: Male ☐ Female ☐ Age: Place of Birth:

Current Doctor: Office Phone #: ( )

School (If applicable) :

Permission to send School Excuse directly to school? YES ☐ NO ☐

PARENT/GUARDIAN INFORMATION

Parent/Guardian (First, M.I., Last): DOB: / /

Relationship to Patient: Social Security #: - -

Parent/Guardian E-Mail:

Address:

City: State: Zip:

Home Phone: ( ) Cell Phone: ( )

Permission to leave message? Home YES ☐ NO ☐ Cell YES ☐ NO ☐ E-Mail YES ☐ NO ☐

PHARMACY INFORMATION

Pharmacy Name:

Address: Phone #: ( )

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:
Policy Holder Sex: Male ☐ Female ☐	Policy Holder DOB: / /
Policy Holder SSN#: - -	Relation to Patient:
ID #:	Group #:

Secondary Insurance:	Policy Holder Name:
Policy Holder Sex: Male ☐ Female ☐	Policy Holder DOB: / /
Policy Holder SSN#: - -	Relation to Patient:
ID #:	Group #:

Patient or Parent/Guardian Signature | Relationship to Patient | Date

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INITIAL HISTORY QUESTIONNAIRE

Patient Name (First, M.I., Last) : _____ **DOB:** _____/_____/_____

Form Completed By: _____ **Date Completed:** _____/_____/_____

HOUSEHOLD

# of BROTHERS:_____ ***# of SISTERS:_____***

What is the child's living situation if not with both biological parent?

☐ Joint custody ☐ Single custody ☐ Lives with adoptive parents ☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

BIRTH HISTORY ☐ Don't know birth history

Birth Weight _____

Was the baby born at term? _____ or _____ weeks

Was the delivery ☐ Vaginal ☐ C-Section
If C-Section why? _____

Were there any prenatal or neonatal complications? ☐ Yes ☐ No Explain_____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

Did your baby go home with mother from the hospital? ☐ Yes ☐ No Explain _____

During pregnacy, did mother:

Use tobacco ☐ Yes ☐ No
Drink Alcohol ☐ Yes ☐ No
Use Drugs or Medication ☐ Yes ☐ No
What _____
Used Prenatal Vitamins ☐ Yes ☐ No
When_____

GENERAL DK= Don't Know

Does your child have ANY serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK
Explain

_____

Has your child had ANY surgery? ☐ Yes ☐ No ☐ DK Explain

_____

Has your child EVER been hospitalized? ☐ Yes ☐ No ☐ DK Explain

_____

Is your child allergic to ANY medicine or drug? ☐ Yes ☐ No ☐ DK Explain

_____

Is there any important family medical history that we should be aware of?

_____