Dr. Edgar R. Mejia MD
Dr.Gloria M. Mejia MD
760 Market Street. Paterson, NJ 07513
Tel. 973-523-8083 Fax. 973-523-1133
www.kiddyclinic.com

PATIENT REGISTRATION

DATE

NAME		M F DATE OF BIRTH		AGE
STREET ADDRESS		CITY STATE, ZIP		PHONE ( )
SCHOOL		REFERRED BY		
FATHER'S NAME	OCCUPATION / EMPLOYER	DATE OF BIRTH	WORK PHONE ( )	S.S. #
MOTHER'S NAME	OCCUPATION / EMPLOYER	DATE OF BIRTH	WORK PHONE ( )	S.S. #
GUARDIAN (OTHER, SELF)	OCCUPATION / EMPLOYER	DATE OF BIRTH	WORK PHONE ( )	S.S. #
EMERGENCY CONTACT (OTHER THAN PARENTS)		ADDRESS		PHONE ( )
CLOSEST RELATIVES (NOT AT YOUR ADDRESS)		ADDRESS		PHONE ( )

INSURANCE & BILLING INFORMATION

PERSON RESPONSIBLE -	☐ FATHER ☐ MOTHER ☐	RELATIONSHIP	
BILLING ADDRESS			PHONE #

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY		ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME		I.D. #	GROUP #	BENEFIT CODE
2) INSURANCE COMPANY		ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME		I.D. #	GROUP #	BENEFIT CODE
OTHER COVERAGE				

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. _____ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME *(please print)* ..... DATE .....

PARENT / GUARDIAN *(please print)* ..... SIGNATURE .....

KIDDY CLINIC pediatrics

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PATIENT QUESTIONNAIRE

Completed by _____ Relation _____

Please check [Y] yes or [N] no, circle or explain where required. N/A-Not Applicable

Reason for today's visit -

Previous medical care - Dr. _____ Dental Care [Y] [N] Eye Exam [Y] [N]

PREGNANCY & BIRTH

Mother's age at pregnancy? _____
Any illness during pregnancy? [Y] [N] _____
Medications during pregnancy? [Y] [N] _____
(exclude vitamins & iron) _____
Smoking - alcohol - street drugs - during pregnancy? _____
Was baby early - late - on time? _____
Type of delivery? _____ Birth weight _____ Length _____
Complications? [Y] [N] _____ Apgar _____
Problems with baby at birth? Breathing [Y] [N] Jaundice [Y] [N]
Other _____
Problems soon after? Nursery or home? _____

PAST MEDICAL HISTORY

Allergic reactions? medicine [Y] [N] food [Y] [N] Animals [Y] [N]
Insect bites [Y] [N] _____
Medications taken on a regular basis? (exclude vitamins) _____
Immunizations - up to date? [Y] [N] Do you have a record? [Y] [N]
Hospitalizations - (when-where-why?) _____
Serious injuries (when-where?) _____

Red measles	[Y] [N]	Mumps	[Y] [N]	Joint problems	[Y] [N]
Chicken pox	[Y] [N]	Whooping cough	[Y] [N]	German measles (3 day)	[Y] [N]
Scarlet fever	[Y] [N]	Ear infections	[Y] [N]	Rheumatic fever	[Y] [N]
Asthma / Wheezing	[Y] [N]	Eczema / Hives	[Y] [N]	Seizures	[Y] [N]
Anemia	[Y] [N]	Excessive sweating	[Y] [N]	Problems with hearing	[Y] [N]
Bleeding tendency	[Y] [N]	Hepatitis	[Y] [N]	vision	[Y] [N]
Blood transfusions	[Y] [N]	Urinary infections	[Y] [N]	Other _____	[Y] [N]

FEEDING & NUTRITION

Food Allergies
Appetite usually good? [Y] [N]
Colic or feeding problems during the first 3 months? [Y] [N]
Breast fed? [Y] [N] Number of months? [Y] [N]
Formula? [Y] [N] Current brand? _____
Vitamins? [Y] [N] Brand? _____ Fluoride? [Y] [N]
Special diet? [Y] [N] dfgbdfbfg

FAMILY PROFILE

Parents - Married? ☐ Separated? ☐ Divorced? ☐
Father's age? _____ Highest school grade? _____ Health? _____
Mother's age? _____ Highest school grade? _____ Health? _____
(List child's brothers, sisters & their ages)

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems - use abbrev. **(F)** *Father,* **(M)** *Mother,* **(B)** *Brother,* **(S)** *Sister,* **(MM)** *Mother's mother,* **(MF)** *Mother's father,* **(FM)** *Father's mother,* **(FF)** *Father's father,* **(A)** *Aunt,* **(U)** *Uncle,* **(C)** *Cousin*

Anemia/Blood Dis _____
Asthma _____
Mental Retardation _____
Drug Problem _____
Alcoholism _____
Cancer _____
Aids _____
Cystic Fibrosis _____
Musc. Dystrophy _____
Tuberculosis _____
Arthritis _____
Epilepsy / Seizures _____
Heart Disease _____
High Blood Pressure _____
Cholesterol Problem _____
Migraine _____
Sudden Infant Death _____
Birth Defects _____
Early Deafness _____
Diabetes _____

DEVELOPMENT & BEHAVIOR

Age at which child -
Sat alone _____ Walked _____ Used sentences _____
Toilet trained hello sdgfdgfd Bicycled hello sdgfdgfd
Development compared to other children? _____
hello sdgfdgfd
Grade in school ___ Problems in school? [Y] [N] _____
hello sdgfdgfd
Learning problems? [Y] [N] hello sdgfdgfd
Getting along with other children? [Y] [N] _____
Behavior problems? [Y] [N] hello sdgfdgfd
Bad habits? hello sdgfdgfd Bedwetting? [Y] [N]
Nail biting? [Y] [N] Sleeping? [Y] [N] Hobbies - sports -
Use of street or illegal drugs? [Y] [N] _____

SYNOPSIS