Child Registration Form

University Surgical Associates
Exceptional surgeons. Compassionate care.

Patient Information

Account # Date

Child's Name (First, Middle, Last) Date of Birth SS#

Street Address Apt. #

City State Zip Home Phone

Reason for Visit

Patient Name (First, Middle, Last) Referring Physician

Current condition/complaint

OFFICE USE ONLY

(RUE) BP Height

(LUE) BP Weight

Heart Rate Temp.

Resp. Rate

Allergies

Reactions

History of present illness

Previous Hospital Admissions/Surgeries/Serious Injuries

Current Medications

Patient Name:

Patient Medical History

Diabetes	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart issues	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Bleeding tendancy	☐ Yes	☐ No
Recent infections	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Hepatits	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Family history of polyps	☐ Yes	☐ No
Family history of cancer	☐ Yes	☐ No
Family history of breast cancer	☐ Yes	☐ No

Patient Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco ☐ Never ☐ Previously, but quit Current packs/day

Use of Drugs ☐ Never Type/Frequency

Family Medical History

	Age	Diseases	Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

Review of Systems

Patient Name: _____

Please check appropriate answer

CONSTITUTIONAL SYSTEM

Good general health	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

EYES

Eye disease or injury	☐ Yes	☐ No
Wear glasses/contact lenses	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

EARS/NOSE/THROAT

Hearing loss/ringing	☐ Yes	☐ No
Chronic sinus problems	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Bad breath or bad taste	☐ Yes	☐ No
Sore throat/voice change	☐ Yes	☐ No

CARDIOVASCULAR

Heart problems	☐ Yes	☐ No
Chest pain or angina	☐ Yes	☐ No
Palpitation	☐ Yes	☐ No
Shortness of breath walking	☐ Yes	☐ No
Shortness of breath lying	☐ Yes	☐ No
Swelling of feet/ankles/hands	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No

RESPIRATORY

Chronic coughing	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No

MUSCULOSKELETAL

Joint pain/stiffness/swelling	☐ Yes	☐ No
Weakness in muscles/joints	☐ Yes	☐ No
Muscle pain or cramps	☐ Yes	☐ No
Cold extremities	☐ Yes	☐ No
Difficulty walking	☐ Yes	☐ No

GASTROINTESTINAL

Loss of appetite	☐ Yes	☐ No
Change in bowel movements	☐ Yes	☐ No
Painful bowel movements	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Rectal bleeding/blood in stool	☐ Yes	☐ No
Abdominal pain/heartburn	☐ Yes	☐ No
Peptic ulcer	☐ Yes	☐ No
Unable to restrain stools	☐ Yes	☐ No
Colon cancer	☐ Yes	☐ No
Polyps	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No

Have you ever had the following tests:

Colonoscopy	☐ Yes	☐ No
Barium enima	☐ Yes	☐ No
Flexible sigmoidoscopy	☐ Yes	☐ No

BLOOD AND LYMPH

Slow to heal after cuts	☐ Yes	☐ No
Bleeding/bruising tendancy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Blood clots	☐ Yes	☐ No
Past transfusion	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No

URINARY AND REPRODUCTIVE

Frequent urination	☐ Yes	☐ No
Burning/painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Unable to restrain/dribbling	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Male- testicle pain	☐ Yes	☐ No
Female- pain with periods	☐ Yes	☐ No
Female- irregular periods	☐ Yes	☐ No
Female- vaginal discharge	☐ Yes	☐ No
Female- breast feed	☐ Yes	☐ No
Female- hysterectomy	☐ Yes	☐ No
Female- ovaries removed	☐ Yes	☐ No
Female- birth control	☐ Yes	☐ No
Female- age started period		

Urinary/reproductive, continued

Female- last menstral period (date)	
Female- # of pregnancies	
Female- # of miscarriages	
Female- Age of first pregnancy	
Female- # of children	
Female- date of last pap smear	

SKIN AND BREAST

Rash or itching	☐ Yes	☐ No
Breast pain or soreness	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No
Had recent mammogram	☐ Yes	☐ No
Any previous breast surgery	☐ Yes	☐ No

NEUROLOGICAL

Frequent headaches	☐ Yes	☐ No
Light headed or dizzy	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Head injury	☐ Yes	☐ No

ENDOCRINE

Gland/hormone problem	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Excessive thirst/urination	☐ Yes	☐ No
Heat or cold intolerance	☐ Yes	☐ No
Skin becoming dryer	☐ Yes	☐ No

PSYCHIATRIC

Memory loss/confusion	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Problems sleeping	☐ Yes	☐ No

Parental Information

Patient Name:

Father's Name (First, Middle, Last) | Date of Birth | SS#

Street Address | Apt. #

City | State | Zip | Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Mother's Name (First, Middle, Last) | Date of Birth | SS#

Street Address | Apt. #

City | State | Zip | Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Legal Guardian/Custodian Information

Name (First, Middle, Last) | Date of Birth | SS#

Relationship to Child/Minor | Street Address | Apt. #

City | State | Zip | Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Emergency Contact

Name (First, Middle, Last) | Relationship to Patient

Street Address | Apt. #

City | State | Zip | Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Billing Information

Patient Name:

Billing Name | Date of Birth | SS#

Street Address | Apt. #

City | State | Zip | Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Insurance Information

Primary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Primary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Secondary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Secondary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Authorization to Obtain Treatment

Patient Name:

Parent or Guardian:

In the event you are not able to bring your child to the office for treatment, we must have an authorization on file stating whom you authorize to obtain treatment for your child in your absence. Please complete the requested information below, then sign and date the authorization form.

Thank you.

Patient Name (First, Middle, Last) Date of Birth

Parent Names

Legal Guardian/Custodian Names

I authorize the following person(s) to obtain treatment for the patient listed above from the physicians of University Surgical Associates:

Name Name

Name Name

Name Name

This authorization shall remain in effect indefinitely, unless withdrawn by my written request:

Signature Relationship to Patient

Withdrawal of Authorization

I request the above authorization be withdrawn effective on this date: _____

Signature Date