Family Health Care of Northwest Ohio, Inc.
Registration Form: Please complete ALL sections

PATIENT INFORMATION

Last Name	First Name	MI	Maiden Name	Date of Birth	Soc. Security Number

Sex at Birth: ☐Male ☐Female

Sexual Orientation: ☐Straight ☐ Lesbian/Gay ☐Bisexual ☐Don't Know ☐Something Else

Gender Identity: ☐Male ☐Female ☐Other ☐Transgender Male (Female to Male) Transgender Female (Male to Female) ☐Choose not to report

Address	City	State	ZIP

PREFERRED PROVIDER: ☐ Megan Wehri, CNP ☐ Brittany Mawer, CNP ☐ Corie Mueller, PCNP ☐ Kendra Cross, CNP ☐ Dr. Gatz ☐ No Preference ☐ Dental Patient Only

CONTACT INFORMATION

Home Phone ( )	Day/ Work Phone ( )	Cell Phone ( ) *For call/text*: FHC is not responsible for usage or data rates if applicable.

Special instructions for telephone calls:

Preferred Contact Method: ☐ Phone ☐ Mail ☐ E-Mail:

Please list your email address for access to your medical records through our secure online patient portal:
Email Address:

EMERGENCY CONTACT: Name: Phone Number: Relationship:

TOTAL NUMBER OF HOUSEHOLD MEMBERS:

HOUSEHOLD INCOME: ☐$0-$10,000 ☐$10,001-$20,000 ☐$20,001-$30,000 ☐$30,001-$40,000 ☐$40,001-$50,000 ☐$50,001-$60,000 ☐$60,001-$70,000 ☐ $70,001-$80,000 ☐ $80,001-$90,000 ☐ $90,001-$100,000 ☐$100,001+ ☐Decline Sliding Fee

PLACE OF EMPLOYMENT: **Preferred Pharmacy:**

RESPONSIBLE PARTY (Required for patients under 18 years of age)

Last Name	First Name	MI	Soc. Sec. Number	Birth Date	Relationship

INSURANCE INFORMATION (Please present ALL insurance cards and a photo ID to the receptionist)

Primary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay	Policy #	Relationship
	Address				Group #	
Secondary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay	Policy #	Relationship
	Address				Group#	

PATIENT INFORMATION FOR STATISTICAL REPORTING ONLY: PLEASE INDICATE ANSWERS FOR PATIENT

Please **X** to indicate your race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race

Please **X** to indicate if you are Hispanic: ☐ Yes ☐ No

Please **X** to indicate if you are a Migrant worker: ☐ Yes ☐ No

Please **X** to indicate if you are a Seasonal worker: ☐ Yes ☐ No

Please **X** to indicate your preferred language: ☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other

Please **X** Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

Please **X** Student Status: ☐ Full-Time Student ☐ Part-Time Student

Please **X** if you are a: ☐ Veteran ☐ Smoker

Please **X** if you are: ☐ Homeless ☐ Doubling Up ☐ Transitional ☐ Shelter ☐ Street

Please list any spiritual/cultural beliefs that may affect your medical care:

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.
I have received a copy of the Notice of Privacy Practices
The preceding information is true to the best of my knowledge.

Patient Name (Printed) **Signature of Patient/Responsible Party** **Date**

Family Health Care of Northwest Ohio, Inc.

Pediatric Medical History Form

Patient Name:_____ Date of Birth: _____

Parent/Guardian Name: _____ Today's Date:_____

Relationship to Patient: □Mother □Father □Grandparent □Foster Parent □Other Relative □Other: _____

Where does the patient live? □House/Apt w/ Family □House/Apt w/ relative or friends □Shelter □Other: _____

Does anyone else take care of the patient? If yes, who? _____

Has the patient received health care elsewhere? If yes, where? _____

How would you rate this patient's health? □Excellent □ Good □Fair □Poor

Present Health Concerns:_____

MEDICATIONS:

Medication Name	Dose	Frequency

MEDICATION/FOOD ALLERGIES:

Allergy	Reaction or Side Affect

HOSPITALIZATONS/SURGERIES: *Please list all prior hospitalizations, surgeries and dates.*

Reason/Type	Date/Location

CHILDS MEDICAL HISTORY: Has the patient ever had any of the following conditions/illnesses?

Condition	No	Yes	Details (If Yes)
Chicken Pox			
Measles			
Mumps			
Whooping Cough			
Rubella			
Seizures			
Jaundice			
Infections			
Chronic Rashes			
Chronic Diarrhea/Constipation			
Dental Problems			
Poor Feeding			
Recurrent Bloody Noses			
Broken Bones/Muscular Abnormalities			
Congenital Abnormalities			
Recurrent Ear Infections			
Seasonal Allergies			
Respiratory/Lung Problems			
Heart Conditions			
Vision Problems			
Other Conditions not specified			

IMMUNIZATIONS: Is the patient up to date on immunizations? ? □ Yes □ No

Include records if available or provide contact info for agencies that would have records: _____

Has the patient had any adverse reactions to vaccines? □ Yes □ No If yes, to which vaccine: _____

What was the reaction: _____

PREGNANCY & BIRTH: Is the patient your child by: □Birth □Adoption □Stepchild □Other: _____

Were there any medical problems during pregnancy? □ Yes □ No If yes, explain: _____

Mothers Exposure to any of the following during pregnancy-If yes, give details:

Alcohol	□ No	□ Yes	Details (If Yes):
Drugs (Recreational/Smoking)	□ No	□ Yes	Details (If Yes):
Medications/Supplements	□ No	□ Yes	Details (If Yes):
Toxins	□ No	□ Yes	Details (If Yes):
Diseases	□ No	□ Yes	Details (If Yes):

Were there any medical problems during labor and delivery? □ Yes □ No If yes, please explain: _____

Any problems with the child after birth such as: Trouble breathing, jaundice (yellowness), etc. after the patient's birth?

□ Yes □ No If yes, please explain: _____

Where was the patient born? _____ Delivering Doctor: _____

Method of Delivery: □ Vaginal □ Caesarean □ Spontaneous □ Induced

Gestational Age: _____ weeks

Childs Birth Weight: _____ lb. _____ oz. Length: _____ Inches

Interventions needed during delivery? □ Pain Medications □ Epidural □ Forceps □Vacuum □ Pitocin □ other: _____

Hearing Screen: □ Pass □ Fail □ Unknown Congenital Heart Screen: □ Pass □ Fail □ Unknown

NUTRITION & FEEDING: Type of feeding as a newborn: □ Breastfed □ Formula If breastfed, for how long: _____

Has the patient had any feeding/dietary problems or restrictions? □ Yes □ No If yes, please explain: _____

Milk intake: □ Soy Milk □ Rice Milk □ Cow's Milk (____ %) □ other, please specify _____ # of ounces/day _____

Introduction to solid foods □ Yes □ No If yes, what & when: _____ Current Diet (Picky Eater) □ Yes □ No

Has the patient been seen by a dentist? □ Yes □ No If yes, Name of Dentist and date of last visit _____

What is the water source in the home? □ City □ Well

MILESTONE DEVELOPMENT:

Do you have any concerns about growth or progress made in such areas as rolling over, sitting, walking, riding a tricycle, dressing self, or feeding, self? □ Yes □ No If yes, please explain: _____

Do you have concerns about language or speech development? □ Yes □ No If yes, please explain: _____

When the patient is in the car, do they use: □ Infant Seat □ Booster Seat □ Seatbelt Only Other: _____

Does the patient wear a helmet while riding a bike? □ Yes □ No

BEHAVIOR & EMOTIONAL HISTORY: Are there concerns about the patient's behavior? □ Yes □ No, If yes, explain: _____

At home: Describe relationships with friends, family, siblings: _____

Does the patient do/have any of the following: □ Nail biting □ Nightmares □ Bad temper □ Fears □ Anxious/Irritable

□ Bedwetting □ Jealousy □ Unable to toilet train □ Breath holding □ Self Harm □ Sleep Disturbances

SOCIAL HISTORY: Are the patient's parents: □ Married □ Never Married □ Separated □ Divorced □ Other: _____

Do any household members smoke? □ Yes □ No

Is there any violence in the home? □ Yes □ No

Are there guns in the home? □ Yes □ No If yes, are they locked up away from children? _____

Do you have concerns regarding the patient's: □Alcohol Use □Tobacco Use □Sexual Activity □ Aggressive behavior

How many hours per day does the patient spend: Watching TV _____Computer/iPad _____Playing Video Games _____

Do you have any concerns about lead exposure due to having an old home, plumbing, or peeling paint? □ Yes □ No

Do you have working smoke detectors in your home? □ Yes □ No

Who lives at home with the patient?

Name	Age	Relationship

SCHOOL HISTORY: Does the patient attend school/preschool? □ Yes □ No If yes, current grade in school: _____

Do you have concerns with how the patient is doing in school? □ Yes □ No If yes, please explain: _____

Any concerns about relationships with teachers or other students? □Yes □ No If yes, please explain: _____

FAMILY HISTORY: *Please indicate with a check (√) who in the patient's family has had the following conditions.*

In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer	Depression/ Mental Health Issues	Drug Exposure	Other
Mother		□	□	□	□	□	□	□	□	□	
Father		□	□	□	□	□	□	□	□	□	
Siblings		□	□	□	□	□	□	□	□	□	
Maternal Grandmother		□	□	□	□	□	□	□	□	□	
Maternal Grandfather		□	□	□	□	□	□	□	□	□	
Paternal Grandmother		□	□	□	□	□	□	□	□	□	
Paternal Grandfather		□	□	□	□	□	□	□	□	□	

Other pertinent family history: _____

Please list the pharmacy you are currently using: _____

Any additional information: _____

Parent/Guardian Signature: _____ Date: _____

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