Fitlife Pediatric Consultants

NEW PATIENT REGISTRATION FORM

Patient Last Name: _____ First Name: _____

DOB: _____ Gender: _____ Primary Language:_____

Ethnicity: __Hispanic __Non-Hispanic __Unknown

Race: __Asian __Black __Hawaiian __White

Mailing Address:

_____

Street Address City State Zip Code

Primary Number: (___)_____ Is this a cell? Yes No

Parent/Guardian 1 Name: _____ Date of Birth:_____

Relation to patient: _____ Lives with patient? Yes No

Cell Phone: (____) _____ Work Phone: (____)_____

Home Email: _____ Employer: _____

Parent/Guardian 2 Name: _____ Date of Birth:_____

Relation to patient: _____ Lives with patient? Yes No

Cell Phone: (____) _____ Work Phone: (____)_____

Home Email: _____ Employer: _____

Insurance Information:

Subscriber's Last Name	Subscriber's First Name	MI	DOB

Gender	Insured's Employer	Insurance Company Name

Policy/ID #	Group #	Policy Effective Date

Additional Insurance Information:

Subscriber's Last Name	Subscriber's First Name	MI	DOB

Gender	Insured's Employer	Insurance Company Name

Policy/ID #	Group #	Policy Effective Date

I certify that the information above is complete and correct.

Parent/Guardian Signature	Parent/Guardian (Print)	Date

Prenatal Care/ Birth History

Type of Delivery: NSVD____ C-Section____ Why?_____

Gestation _____ Weeks Male____ Female____

Complications During Delivery? _____

Maternal Infections During Pregnancy? Yes____ No____ If Yes, Explain _____

Hospital _____ Length of Stay _____

Gestation _____ Weeks Birth Weight_____ Any Milk Allergies? Yes____ No ____

Feeding/ Nutrition: Breast____ Formula:____ Name of Formula:_____

Medication List (please list all medications patient is currently taking)

_____ _____

_____ _____

_____ _____

_____ _____

Allergies Yes____ No____ If Yes, please list allergies

_____ _____

_____ _____

_____ _____

Past Medical History

Asthma	Yes___	No___	Gastritis	Yes___	No___
Anemia	Yes___	No___	Hemophilia	Yes___	No___
Bleeding Disorders	Yes___	No___	Kidney Disease	Yes___	No___
Bronchitis	Yes___	No___	Lupus	Yes___	No___
Cancer	Yes___	No___	Neurological Disorders	Yes___	No___
Congenital Heart Disease	Yes___	No___	Psychiatric Disorders	Yes___	No___
Cystic Fibrosis	Yes___	No___	Seizure Disorders	Yes___	No___
Diabetes	Yes___	No___	Sickle Cell Trait/Disease	Yes___	No___
Esotropia/ Exotropia	Yes___	No___	Thalassemia	Yes___	No___
Gastrointestinal Disorders	Yes___	No___	Thyroid Disorders	Yes___	No___

Other: _____

Family History

Member	Age	Health Condition
Father		
Mother		
Sibling Male/ Female		
Sibling Male/ Female		
Sibling Male/ Female		

Any history of SIDS in the family? Yes____ No____

Surgical History (please list any surgeries the patient has had and age at time of surgery)

_____

_____

_____

_____

Child Developmental History

Has he/she had any speech or language problems?	Yes____	No____
Has he/she had any hearing problems?	Yes____	No____
Did he/she reach their milestones at appropriate ages?	Yes____	No____
Has your child shown adequate growth?	Yes____	No____
If your child is of school age, has he/she shown any behavior problems?	Yes____	No____
Has your child had to see a specialist?	Yes____	No____
If yes, please list the specialist(s) and explain the reason		
Has your child had any hospitalizations?	Yes____	No____
Where?		
When?		

Does your child attend daycare?	Yes____	No____

Today's Visit

Please explain the reason for today's visit

____
____
____

Has the patient received a Tetanus shot? Yes____ No____ When?_____________

Has the patient had any bad reactions to Immunizations? Yes____ No____

Does the patient currently have any of the following symptoms? (please circle your choices)

Anemia Seizures Recurrent Otitis Media Cough

Recurrent Infections Asthma Bronchitis Fever Diarrhea

Vomiting Sore Throat Ear Pain

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

Patient's Signature:____________________________________ Date:________________________

Authorized Representative Signature: ____

Relationship:__________________________________ Date:________________________

I certify that my dependent(s) or myself, have insurance coverage with ___________________________ and I agree to assign **Damaris Mafut DO**, the insurance benefits that my insurance company shall pay for the services rendered. I understand that I am financially responsible for all of the charges paid or not paid by the insurance company. I authorize the use of my signature in all of the submitted claims to the insurance company. The above mentioned doctor may use my health information to discuss said information with the aforementioned insurance company, as well as his/her colleagues and staff for the sole purpose of obtaining payment for the services rendered and the determination of benefits or the benefits paid for the related services. This consent will end when my current treatment plan is completed or one year from the signed date of this form. I also authorize **Damaris Mafut DO,** to obtain my medical history from any third party provider or share any pertinent medical history with other colleagues for the purpose of discussing my medical management and/or insurance related questions or concerns.

Patient Signature or Authorized Guardian: ____

Date: ____

9020 SW 137th Avenue, Suite 200

Miami, Florida 33186

Office (305) 777-3505 Fax (786) 866-2599

FitLifePeds@gmail.com

I, _____ have received a copy of Fit Life Pediatric Consultants Notice of Privacy Practices.

_____ _____

Signature of Parent Date

Patient's Name: _____