KidsFirst
Tri-cities
CHILDRENS URGENT CARE
KID FRIENDLY QUICK CARE

New Patient Form

Child's Information

First Name: _____ Last Name:_____M.I._____

Birth Date:_____ Primary Care Provider:_____

Social Security Number:_____ Sex: Male / Female (Please Circle)

Parent's Name(s):_____

Primary Phone:_____ Secondary Phone:_____

Street Address: _____

City: _____ State:_____ Zip: _____

Email Address:_____

Preferred Pharmacy with address: _____

Financially Responsibly Party

First Name:_____Last Name:_____M.I._____

DOB:_____ Social Security Number:_____Relation to Child:_____

Emergency Contact

Name:_____

Phone Number:_____

Relationship:_____

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History Form

Patient Name:_____ DOB:_____

Allergies:_____

Current Medications:_____

_____

_____

Medical History (Please Circle)

ADHD	Congenital Heart Disease	Frequent Ear Infections
Acne	Concussions	Frequent UTI's
Asthma	Diabetes	GERD
Bleeding Disorders	Eczema	Heart Murmur

Other:_____

Surgical History (Please specify month and year)

Appendectomy _____ Circumcision _____Reduction of Fracture _____

Adenoidectomy_____Dental _____Hernia _____ Tonsillectomy _____

PE tubes_____

Family History (Please specify which family member has a condition)

Asthma_____ Heart Disease_____ Obesity_____

Birth Defects_____HighCholesterol_____Seizure Disorder_____

Cancer_____Hypertension_____SIDS_____

Diabetes_____Mental Illness_____Thyroid Disease_____

Social History

Does anyone smoke inside or outside the home? _____

Number of adults in the household?_____

Number of children in the household?_____

Number of pets in the household?_____

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HIPPA Disclosure Form

Patient Name:_____ Birth Date:_____

(Please Circle)

May we identify ourselves over the phone? Yes / No

May we leave voice messages? Yes / No

I, _____, hereby authorize Kids First Children's Urgent Care to release my dependent's medical information (appointments, labs, x rays, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family member:

Name:_____DOB:_____ Relation:_____

Name:_____DOB:_____ Relation:_____

Name:_____DOB:_____ Relation:_____

I further release my medical information to the following physicians, clinics, hospitals and/or schools:

Name:_____

Name:_____

Name:_____

Patient/Guardian Signature_____

Relationship to patient:_____Signature Date:_____