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MISSION
FAMILY MEDICINE

1785 Garden Street Titusville, Fl 32796

www.missionfamilymed.com

Brittany Marshall, MD
Grant Marshall, MD
Matt Baker, PA-C

Pediatric Patient Registration

Patient Information:

Last Name: _____ First Name: _____ Middle: _____ Nickname: _____

Birth Date: _____ Birth Weight: _____ Age: _____ Sex: M F

Address: _____

Primary Language: _____ **Ethnicity**: Hispanic Non-Hispanic Unknown

Race: Asian African American Hawaiian White

Sibling's Name and Age:

_____

Parent's Information:

Mother's Legal last name: _____

First Name: _____

Birth Date: _____

Cell: _____

Occupation: _____

Email: _____

Father's Legal last name: _____

First name: _____

Birth Date: _____

Cell: _____

Occupation: _____

Email: _____

Pregnancy and Birth Information:

Medical problems during this pregnancy:

_____

_____

Was baby born within two weeks of expected day? Yes No Early Late

Delivery was: Vaginal delivery Caesarean Section

Where was baby born? _____ How many days in the hospital? _____

Were there any complications for the baby while in the hospital? Yes No If yes, please explain:

_____

Was baby breast fed? Yes No If yes, how long? _____

Past Medical History:

Where has your child gone for medical check-ups until now? _____

What is the date of his/her last medical checkup? _____

What is the date of your child's last dental checkup and where? _____

Any reactions to medications, foods, insect bites? YES NO If yes, which ones? _____

Has your child had any reactions to any immunizations? YES NO If yes, which ones? _____

Any hospitalizations other than at birth? YES NO If yes, age and reason: _____

Any serious injuries? YES NO If yes, describe injuries: _____

Does anyone in the household smoke? YES NO If yes, whom? _____

Do you have pets? YES NO If yes, what kind? _____

Please check the boxes below if your child has had any of the following:

☐ Allergies	☐ Feeding or Eating Problems	☐ Measles	☐ Seizures
☐ Asthma or Recurrent Cough	☐ Hearing Problems	☐ Meningitis	☐ Throat problems or Tonsilitis
☐ Broken Bone (s)	☐ Heart Murmur	☐ Mumps	☐ Tooth Problems
☐ Chickenpox	☐ Knocked Unconscious	☐ Poison Ingestion	☐ Urinary Problems
☐ Eye or Ear Problems	☐ Learning/Developmental issues	☐ Pneumonia	☐ Vision Problems

☐ Other illnesses or injuries your child has had:

_____

Medications: **Please list all current medications taken and how often they are taken:**

_____

_____

_____

_____

In Case of Emergency:

1) Name of local friend or relative: _____ Relationship to Patient: _____

   Contact Number: _____

2) Name of local friend or relative: _____ Relationship to Patient: _____

   Contact Number: _____

Family Medical History:

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Dad	Dad's Mom	Other Relative
Alcoholism / Drug abuse									
Alzheimers									
Autoimmune Disease									
Bleeding or Clotting Disorder									
Cancer Breast									
Cancer Colon									
Cancer Ovarian									
Cancer Prostate									
Cancer Other Type									
Coronary Artery Disease (e.g. heart attack, angina)									
Depression / Suicide / Anxiety									
Diabetes									
Genetic Disorder (explain)									
Heart Disease									
High Blood Pressure - Hypertension									
High Cholesterol									
Hypothyroidism / Thyroid Disease									
Kidney Disease									
Kidney Stones									
Osteoporsis									
Other (list below)									
If deceased, put age and cause									

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Test Results and Authorization Form
Patient authorization for use and disclosure of Protected Health Information (PHI)

I authorize Mission Family Medicine Staff to leave a message regarding my medical care at the following telephone number(s):

Telephone_____

Telephone_____

I authorize Mission Family Medicine Staff to discuss or leave a message regarding my medical care with the following individual(s):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

_____
Patient Name

_____
Date of Birth

_____
Signature

_____
Signature Parent/Guardian