Masters Family Medical, PLLC
Pediatric Registration Form

234 West Central Ave
Jamestown, TN 38556
(931) 879-8139

117 West Commercial Ave
Monterey, TN 38574
(931) 310-2900

PATIENT INFORMATION

NAME OF MINOR/CHILD: _____
LAST NAME FIRST NAME MIDDLE INITIAL

SEX ☐ M ☐ F AGE_____ DATE OF BIRTH_____ SSN _____

MAILING ADDRESS _____
STREET CITY STATE ZIP

PARENT/ GUARDIAN _____ TELEPHONE_____

INSURANCE COVERAGE

FATHER'S/GUARDIAN'S NAME_____

ADDRESS (IF DIFFERENT FROM PATIENT'S)

_____

_____

HOME PHONE_____

WORK PHONE_____

EMPLOYER_____

SSN#_____ DOB_____

DO YOU HAVE INSURANCE COVERAGE FOR MINOR/CHILD?
☐ Y ☐ N

PLAN NAME_____

PHONE # _____

ADDRESS_____

_____

GROUP # _____

POLICY # _____

MOTHER'S/GUARDIAN'S NAME_____

ADDRESS (IF DIFFERENT FROM PATIENT'S)

_____

_____

HOME PHONE_____

WORK PHONE_____

EMPLOYER_____

SSN#_____ DOB_____

DO YOU HAVE INSURANCE COVERAGE FOR MINOR/CHILD?
☐ Y ☐ N

PLAN NAME_____

PHONE # _____

ADDRESS_____

_____

GROUP # _____

POLICY # _____

EMERGENCY CONTACT

NAME_____ RELATIONSHIP_____ PHONE#_____

NAME_____ RELATIONSHIP_____ PHONE#_____

IMMUNIZATIONS

CHECK WHETHER OR NOT YOU MINOR/CHILD HAS BEEN GIVEN THE FOLLOWING IMMUNIZATIONS. IF YES, PLEASE PROVIDE THE DATE GIVEN.

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
☐	☐	_____	DPT3 SHOTS (3)	☐	☐	_____	POLIO BY MOUTH SHOTS (3)	☐	☐	_____	DIPHTHENIA TETANUS
☐	☐	_____	DPT BOOSTER SHOTS	☐	☐	_____	MEASLES VACCINE	☐	☐	_____	HEPATITIS B
☐	☐	_____	POLIO SHOTS (3)	☐	☐	_____	MUMPS VACCINE	☐	☐	_____	TUBERCULIN TEST
☐	☐	_____	POLIO BOOSTER SHOTS	☐	☐	_____	RUBELL VACCINE				IF SO, PLEASE LIST RESULTS _____

FAMILY HISTORY

HAS ANY MEMBER OF THE FAMILY OR CLOSE RELATIVE HAD:

YES	NO		YES	NO		YES	NO	
☐	☐	ARTHRITIS	☐	☐	DIABETES	☐	☐	MENTAL ILLNESS
☐	☐	ASTHMA	☐	☐	HEART DISEASE	☐	☐	MIGRAINE
☐	☐	CANCER	☐	☐	HEMOPHILIA-BLEEDER	☐	☐	TUBERCULOSIS
☐	☐	CHEMICAL DEPENDENCY	☐	☐	HIGH BLOOD PRESSURE	☐	☐	OTHER
☐	☐	CONVULSION OR EPILEPSY	☐	☐	KIDNEY DISEASE			IF SO PLEASE LIST_____

BIRTH HISTORY

HOSPITAL_____ OB_____ DELIVERY TYPE_____
BIRTH WEIGHT _____ BIRTH LENGTH_____ COMPLICATIONS_____
DISCHARGE WEIGHT_____ COMPLICATIONS POST DELIVERY_____

HEALTH HISTORY

MINOR/CHILD'S PHYSICIAN_____ CITY/STATE_____ PHONE#_____
DATE OF LAST PHYSICAL EXAM_____ RESULTS_____

IS MINOR/CHILD TAKING ANY MEDICATIONS? ☐ Y ☐ N IF SO, PLEASE LIST_____

HAS MINOR/CHILD BEEN HOSPITALIZED? ☐ Y ☐ N IF SO, PLEASE DESCRIBE_____
_____

ALLERGIES_____

HAS MINOR/CHILD HAD ANY HISTORY OR DIFFICULTY WITH THE FOLLOWING

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S/H.I.V.	☐	☐	CHICKEN POX	☐	☐	HEART PROBLEMS	☐	☐	RHEUMATIC FEVER	☐	☐	ANEMIA
☐	☐	CONSTIPATION	☐	☐	DIARRHEA	☐	☐	HEPATITIS	☐	☐	SINUS PROBLEMS	☐	☐	ASTHMA
☐	☐	CONVULSIONS	☐	☐	KIDNEY DISEASE	☐	☐	SPEECH PROBLEMS	☐	☐	BED WETTING	☐	☐	DIABETES
☐	☐	LEAD POISONING	☐	☐	THYROID DISEASE	☐	☐	BIRTH DEFECTS	☐	☐	DRUG/ALCOHOL ABUSE	☐	☐	LIVER DISEASE
☐	☐	TUBERCULOSIS	☐	☐	BLADDER ISSUES	☐	☐	EAR INFECTIONS	☐	☐	ABNORMAL BLEEDING	☐	☐	MEASLES
☐	☐	EPILEPSY	☐	☐	MONONUCLEOSIS	☐	☐	VISION ISSUES	☐	☐	CANCER	☐	☐	FAINTING
☐	☐	MUMPS	☐	☐	WORMS	☐	☐	CEREBRAL PALSY	☐	☐	HEARING ISSUES	☐	☐	PNEUMONIA
☐	☐	OTHER	IF SO, PLEASE LIST_____											

RELEASE AND ASSIGNMENT

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MINOR/CHILD'S MEDICAL STATUS.

I CERTIFY THAT MY MINOR/CHILD IS COVERED BY INSURANCE WITH _____ AND ASSIGN
NAME OF INSURANCE COMPANY(IES)
DIRECTLY TO _____ ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES
NAME OF PROVIDER
RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCES. I HEREBY AUTHORIZE THE PRACTITIONER TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

_____
SIGNATURE OF PARENT/GUARDIAN DATE