FAMILY DATA FORM – TRINITY PEDIATRICS

Mother's Name	Father's Name			
Address	(If different)			
Primary Phone	Primary Phone			
Alternate Phone	Alternate Phone			
Occupation	Occupation			
Employer	Employer			
Email	Email			

Please Circle: MARRIED	IN RELATIONSHIP	SEPERATED	DIVORCED	
If parents are separated/divo	rced or do not reside togetl	ner, please indicate o	custodial and/or living arrangement	is:

If parents are separated/divorced or not married, who has the legal responsibility for health insurance coverage:				
Name:	Phone:			
Address:	Relationship:			

Primary Insurance		Policy Holder's Name		
Policy Holder's DOB	Policy Holder's SS#			
ID#	Group #	Effective Date		

^{**}Please make sure Dr. Gloria Roetzer is listed as child's Primary Care Provider**

Secondary Insurance		Policy Holder's Name		
Policy Holder's DOB		Policy Holder's SS#		
ID#	Group #	Effective Date		

PHARMACY Name and Address:

Child Name	DOB	Primary	Race	Ethnicity	Lives with:
Print on back for more	mm-dd-	Language			Circle all that apply
blessings	уууу				
					Mother Father Guardian
					Mother Father Guardian
					Mother Father Guardian
					Mother Father Guardian
					Mother Father Guardian

List below any authorized individual(s) other than parent/guardian. (Stepparents, grandparents, babysitters, etc.)

Name	Relationship	Phone #	Authorized to: Circle all that apply
			Schedule/attend appt. Make medical decisions
			Emergency Contact
			Receive/Provide medical and financial info.
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			Emergency Contact
			Receive/Provide medical and financial info.

Parent Signature: _	 	
Date		

Trinity Pediatrics - Health History Form - Initial Visit

Child's Name:	Your Name:
Date of Birth	Relationship to Child:
Complications during pregnancy or birth? Ever treated for or diagnosed with: Please Circle all that apply. Asthma Wheezing Allergies: Medication Allergies Eczema Recurrent Ear Infections Pneumonia Urinary Tract Infection Seizures Anemia Other: Current Medications and dose:	Vitamins/ OTC medications: Any feeding or dietary problems? Y / N Who lives in the home? # of Adults: # of Children: Does child attend Daycare? Y / N School performance concerns? Y / N School Name: Religious Preference: Sports/Exercise Screen time: hours/day Pets: Do any household members smoke? Y / N Current smoke alarms/ CO2 detectors? Y / N Are firearms locked safely away from children? No Firearms / Y / N

Family History: This is for the child, not the parent. Please indicate alive or deceased.

	Father	Mother	Paternal Grand father	Paternal Grand mother	Maternal Grand father	Maternal Grand mother	Sibling	Other
Asthma								
Allergy								
Anemia/ Blood disorder								
Cancer If yes, specify what type								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Stroke								
Diabetes: Type 1 or 2								
Thyroid Disease								
Migraines								
Mental Illness								
Alcohol/drug Abuse								
ADHD								
Other								