

**PETERKORT**  
Peterkort Centre 1  
9555 SW Barnes Rd, Suite 301  
Portland, Oregon 97225  
(503) 297-3371 Fax: 297-7975

# THE CHILDREN'S CLINIC, P.C.

**TUALATIN**  
Meridian Park Medical Plaza 2  
19260 SW 65th Ave, Suite 340  
Tualatin, Oregon 97062  
(503) 691-9777 Fax: 692-6736

**Child's Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_  
Last Name First Name Middle Name

**Sex** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Referred By** \_\_\_\_\_

ACCOUNT INFORMATION (Please fill out completely)	
Patient's Address _____ Apt # _____	
City _____ State _____ Zip _____ Home Phone _____	
Emergency Contact _____ Phone _____	
Parent / Guardian _____ Date of Birth _____	
(Last) (First) (Middle)	
Employer _____ Occupation _____ Relationship To Patient _____	
Home Phone _____ Email _____ Work Phone _____	
Parent / Guardian _____ Date of Birth _____	
(Last) (First) (Middle)	
Employer _____ Occupation _____ Relationship To Patient _____	
Home Phone _____ Email _____ Work Phone _____	
Insurance Company _____ Insurance Phone _____	
Claim Address _____	
Subscriber _____ Subscriber's Birth Date _____ - _____ - _____ Relationship	
(MO) (DA) (YR)	
ID or SS # _____ Group # _____ Effective Date	
_____ - _____ - _____ (MO) (DA) (YR)	
Co-Payment Fee _____	
Second Insurance Name (if applicable) _____ Insurance Phone _____	
Claim Address _____	
Subscriber _____ Subscriber's Birth Date _____ - _____ - _____ Relationship	
(MO) (DA) (YR)	
ID or SS # _____ Group # _____ Effective Date	
_____ - _____ - _____ (MO) (DA) (YR)	
Co-Payment Fee _____	
<i>I hereby authorize The Children's Clinic, P.C. to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign The Children's Clinic all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I have received a copy of the current Privacy Notice of The Children's Clinic.</i>	
Signed _____ Date _____ - _____ - _____	
(MO) (DA) (YR)	

**Please fill out the following.**

Patient's Siblings \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital status of family?  Single  Married  Separated  Divorced  Other: \_\_\_\_\_

If divorced: Who has custody? \_\_\_\_\_ Visitation rights? \_\_\_\_\_

Any other people living in the home? \_\_\_\_\_

Are there any smokers in the home? \_\_\_\_\_ If yes, who? \_\_\_\_\_

Please answer the following questions:

<b>CHILD'S NAME</b>	<b>TODAY'S DATE</b>
_____	_____
Last Name                    First                    Middle	

**PRE-NATAL AND BIRTH HISTORY OF CHILD**

Pregnancy: Any illnesses or complications? **Y N** \_\_\_\_\_  
Any smoking, alcohol, or recreational drug use during pregnancy? **Y N** \_\_\_\_\_

Delivery: Any complications? **Y N** \_\_\_\_\_  
Baby's Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Head \_\_\_\_\_ Hospital \_\_\_\_\_  
Problems at or after birth? \_\_\_\_\_

Did your baby need any blood transfusions after birth? **Y N**

**CHILD'S ALLERGIES TO**

**Medications** (Date and symptoms): \_\_\_\_\_

**Foods:** \_\_\_\_\_

**PAST MEDICAL HISTORY OF CHILD**

Hospitalizations or outpatient surgeries (when, where and why): \_\_\_\_\_

\_\_\_\_\_

Serious injuries (when, where): \_\_\_\_\_

Previous MD / Clinic \_\_\_\_\_ Dentist \_\_\_\_\_

Have previous records been sent for? **Y N** Fluoride: medication / water / none

Are immunizations up to date? **Y N**

Have you given us a copy of the immunization record? **Y N**

Your child's previous or current conditions: (Circle all relevant)

Recurrent ear infection (>3)	Constipation	Seizures	Mental / Emotional Prob.
Recurrent throat infect. (>3)	Chickenpox	Eye problems	Cigarette smoker
Allergies / Sinus problems	Scarlet fever	Hearing problems	Drug / Alcohol use
Asthma / Wheezing	Stomachaches	Kidney / Bladder infections	Tattoos / Body Piercings
Eczema	Headaches	Blood transfusions	Other: _____

**FAMILY HISTORY OF CHILD**

List child's blood relatives with these problems: (M) Mother, (F) Father, (S) Sister, (B) Brother, (MGM) Mother's mother, (MGF) Mother's father, (PGM) Father's mother, (PGF) Father's father, (A) Aunt, (U) Uncle, (C) Cousin

Heart disease _____	Muscular disease _____	Thyroid disease _____
High blood pressure _____	Neurological disease _____	Anemia _____
High cholesterol _____	Learning problems _____	Cancer _____
Heart attack (age?) _____	Allergies _____	AIDS _____
Birth defects _____	Asthma _____	Tuberculosis _____
Blindness _____	Arthritis _____	Alcohol problem _____
Deafness _____	Diabetes _____	Drug problem _____
Cystic fibrosis _____	Kidney disease _____	Mental illness _____
Migraine _____	G.I. disease _____	Mental retardation _____
Seizure _____	Peptic ulcer _____	Other _____

Is there anything else we need to know about?

Reviewed by M.D.: \_\_\_\_\_