WESTERN NEW YORK PEDIATRIC ASSOCIATES
NEW PATIENT INTAKE FORM

Welcome to Western New York Pediatric Associates PLLC. Please assist us in making sure that your initial visit goes smoothly by completing this form PRIOR to your first visit. If you have more than one child we will need a separate form for each child. We understand that much of the information is repetitive, but please do not put "see siblings chart" on any form. This form is an important part of each child's personal medical record. Thank you for you cooperation.

Patient Name _____ Date of Birth _____□□

Patients Insurance ID# _____

Parent/Guardian _____ Phone No. _____

E-Mail Address _____

Insurance Holder _____ Work/Cell Phone No. _____

Ins. Co _____ Group No. _____ Ins. Holder No. _____

Address _____ City _____ State _____ Zip_____

Emergency Contact Name _____ Emergency Phone No. _____

Drug Allergies _____ Previous Physician _____

Race

_____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian or Other Pacific Island
_____ Black or African American
_____ White
_____ Hispanic
_____ Other

Family Information

	Name	DOB	Occupation
Mother			
Father			
Siblings 1			
2			
3			
4			

Environmental History

Child resides with: Parents Mother Father Other _____

Age of Home _____ No. of Pets _____ Smoke Detector? Y N

Woodburning fireplace Y N No. of Smokers _____ Carbon Monoxide Det. Y N

Firearms in the home Y N Water? Well County

Please complete next page

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Past Medical History (Please do not write in shaded areas)

Physician use only

Past Surgical History (Please do not write in shaded areas)

Date	Surgery	Hospital

Physician use only

Hospitalizations (Please do not write in shaded areas)

Date	Diagnosis	Hospital

Physician use only

Additional Comments Parent/Guardian:

Additional Comments Physician:

_____

Signature of Parent/Guardian **Date**

Physician Initals _____