Washington International Pediatrics

Welcome!

New Patient Registration Form

Patient(s) Information

Child #1:_____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:**_____

Child #2:_____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:**_____

Child #3:_____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:**_____

Child #4:_____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:**_____

Child #5:_____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:**_____

Home Address:_____Apt._____

City:_____State:_____Zip:_____

Child(s) country of birth:_____

Please send us a copy of the immunization record and insurance card front/back

Parent#1

Name:_____ ☐ Male ☐ Female ☐ Other/Non-Binary, DOB:_____

Address (if different from patient's):

Home Address:_____Apt._____

City:_____State:_____Zip:_____

Primary Phone Number:_____E-mail:_____

Profession:_____

Parent#2

Name:_____ ☐ Male ☐ Female ☐ Other/Non-Binary, DOB:_____

Address (if different from patient's):

Home Address:_____Apt._____

City:_____State:_____Zip:_____

Primary Phone Number:_____E-mail:_____

Profession:_____

***Incomplete form will result in a delay to complete registration, and scheduling appointments with the doctors ***

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No Show & Late Cancellation Policy

A great deal of planning is done for your appointment. Changes and cancellations to our schedule without adequate notice are very disruptive to our office. For this reason, we ask that changes to your appointment be made at least 24 hours in advance. A $75 fee will be assessed for late cancellations and no shows.

Late arrival: We will do our best to accommodate patients arriving past their scheduled appointment time for well visits (no more than 15 minutes),but we may need to reschedule those that would lead to significant delays in seeing our other regularly scheduled patients.

_____ _____

Signature Date

School Forms & Health Forms & Other Medical Forms

We charge a $25 administrative fee per (form,letter, medical record request), per child and thrive to provide those in a timely fashion. If not at the time of your visit, we will email the form or mail it to you the following day.

_____ _____

Signature Date

COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

Patient Name: _____**Birthday**: _____

Parent #1: Name _____Phone number:_____
Parent #2: Name_____ Phone number:_____

Please list all of your child's medical conditions.

1) _____
2) _____
3) _____
4) _____

What surgical or medical procedures has your child had in the past?

_____
_____
_____

If parents are not living together, what is the custody arrangement?

_____

Please list everyone who lives in the home (include immediate family, step or half siblings)

	Name	DOB
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____

What medications, herbs, and vitamins/supplements are you currently taking? Remember to include over-the-counter medicines. Please include the doses and how often you take each one.

1) _____
2) _____
3) _____
4) _____

Allergies? YES ___ NO___
If "yes", reactions? _____

Do you have any pets? YES__ NO___, TYPE:_____

Type of Water? City___ Well___

Do you have any gun(s) in the home? YES___ NO___

Does anyone smoke (inside or outside)? Including vapes? YES___ NO____
Marijuana use YES__NO___

Do you have working smoke and carbon monoxide detectors in the home? YES___NO____

Please tell us about medical conditions in your family history, if yes please state whom:

Health history	**YES**	**NO**
Stroke before age 55 yrs		
High Blood Pressure/hypertension		
Diabetes		
Arthritis		
Seizures		
Depression		
Mental illness (anxiety/depression)		
Asthma		
Heart attack		
Elevated cholesterol		
Thyroid disease		
Kidney Disease		
Gastrointestinal disease (ulcer,GER, IBD)		
Bed wetting/enuresis		
Developmental delays/autism		
Cancer		
Allergies		
Hearing Loss		
Other		