

Patients Name:

_____/_____/_____
First MI Last Marital Status: _____

Mailing Address: _____ Apt#: _____

If P.O. Box , provide street address: _____

City: _____ State: _____ Zip Code: _____

Preferred contact phone #: Cell:() _____ Home:() _____ Other:() _____

Patient (Guardian) email address: _____

Do not submit the email address of a minor child.

Date of Birth: ____/____/____ Age _____ Male Female Social Security #: _____-____-_____

*If patient is under 18 years of age or **is cared for** by a guardian or caregiver, who is financially responsible for payment to Evans Medical Group?*

Relationship to patient? _____

_____ Have you submitted the name and all requested information of the person that is financially responsible for the patient, all necessary insurance information and the "Named Insured" as well as all other required information?

This section for Minor Patients or Patients with Guardians

Mother / Father / Guardian's:

_____/_____/_____
First MI Last

Mailing Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Preferred contact phone #: Cell:() _____ Home:() _____ Other:() _____

Social Security#: _____-____-_____ Relationship to patient _____ DOB: ____/____/____

Male
 Female

Consent for treatment:

I am the _____ *custodial parent* _____ *legal guardian* having legal custody of the above-named patient. I authorize the physician and staff at Evans Medical Group any acts that may be necessary or proper to provide for the health care of the stated patient child. Such authorization is in effect until revoked. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained. By signing below, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

Legal Custodian: _____ Date: _____

Name _____ Birthday _____

Nickname: _____ Prefers? Y _____ N _____

Mothers Name _____ Occupation _____

Fathers Name _____ Occupation _____

Please Circle:

Mother Involved- Very Somewhat None Negative

Father Involved- Very Somewhat None Negative

Parents are: Married Separated Divorced Never Married Mom-Deceased Dad-Deceased

Problems with Home Situation Yes No Is Child Adopted? Yes No Foster Child? Yes No

Comments on Parental Situation _____

Step Mothers Name _____ Occupation _____

Step Fathers Name _____ Occupation _____

Lives at Home With: Father Mother Step Mother Step Father Siblings Extended Family

Comments on Living Situation : _____

Siblings Names and Dates of Birth: _____

In Daycare? Yes No School Attended? _____

Smoking at Home? None Outside House Inside House Pets? _____

Firearms at Home? No Yes Yes- Locked

Domestic Violence – (Past or Present) No Yes

Seatbelt/Car Seat Use: Always Most of the time Half of the time Seldom Never

Medical History

Birth Weight _____ Term- Full Premature (_____ weeks) Delivery- Normal Cesarean

Birth Defects? _____

Problems around or at time of Birth _____

Medicines: _____

Allergies? _____

Asthma No Yes Severity- Mild Moderate Severity

Hospitalizations: 0 1 2 More than 2 Details: _____

Diabetes No Yes Diet Controlled? Yes No Type 1 Type 2

Control: Excellent Good Fair Poor

Hospitalization for DKA? 0 1 2 3 >3

Diabetes History: _____

ADD/ ADHD No Yes ADD/ ADHD History _____

Other Psychiatric Problems: No Yes Details _____

Counselor Seeing? _____

History of Cancer? No Yes Bleeding Problems? No Yes

Leukemia? No Yes Leukemia Status: Present Recent Past Distant Past (>5yrs)

Hospitalizations: _____

Surgeries: _____

Family History: (Mother, Father, Sister, Brother)

Asthma: No Yes Details: _____ Bleeding Problems: No Yes Details _____

Sickle Cell: No Yes Details _____ Seizures: No Yes Details _____

Other Problems: _____