Today's Date: **Date of Birth:** **Male or** **Female**

Patient's Last Name: **First:** **Middle:**

Address: **City:** **State:** **Zip Code:**

Home Phone: **Cell Phone:** **SN:**

Preferred Pharmacy: Wal-Mart(Falcon) Safeway(Falcon) Walgreens(Falcon) Other:

Race (Required by Census Bureau):

American Indian
Black or African American
Native Hawaiian and other Pacific Islander
White Hispanic or Latino
Asian
Black Hispanic or Latino
White
Refused

Marital Status: **Single** **Married** **Other**

Employer: **Work phone:**

Emergency Contact: **phone number:**

INSURANCE INFORMATION (Please provide an insurance card and picture id to the receptionist)

Primary Insurance: **Group Number:**

Policy Number: **Co-Payment:$**

Subscriber's name:

DOB: **SSN:**

Patient's Relationship to Subscriber: **Self** **Spouse** **Child** **Other**

Secondary Insurance (if applicable):

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Karen Migliaccio, FNP-C. I understand I am financially responsible for any balance. I also authorize Prairie View Family Care, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature:

____**Date:**__________________

Printed Name of Patient:

____

Relationship to patient: **Self** **Parent** **Guardian** **Other**

NEW PATIENT 0-12 MONTHS

Name ___________________________ DOB___________

Allergies ___________________ Current Medications_____________

Pregnancy/Delivery

Where was your baby born? _____________________
Due Date? Type of birth: vaginal C-Section Breech?
Birth Weight ________ Discharge Weight ______________
Discharge Bilirubin __________ Was Hep B Vaccine given at hospital? _____________
Complications during pregnancy? ___________ during delivery? __________________
Did your baby pass the hearing screen? Yes No
Is your baby having at least one stool a day? Yes No
Has your baby had at least 3 wet diapers in 12 hours? Yes No
Does your baby cry excessively? Yes No
Does your baby have skin problems? ___________________________

Feeding

Are you breastfeeding? Yes No
How often is your baby feeding? _________________ Every hours? ___________
Are you having difficulties with breast feeding? Yes No
If formula feeding, what type of formula and ounces per feeding? _________Ounces ______
What is the source of heat in your home? _________________________
Does anyone smoke in or out of the home? Yes No
Does your baby sleep on his/her back? Yes No
Where does your baby sleep? _____________Type of Bed Crib or Bassinet
Is your hot water heater turned down to less than 120 degrees? Yes No
Does your house have smoke detectors? Yes No
Do you have working carbon monoxide detectors? Yes No
Do you have any concerns that you would like addresses today?