FAMILY DATA FORM – TRINITY PEDIATRICS

Mother's Name	**Father's Name**
Address	(If different)
Primary Phone	Primary Phone
Alternate Phone	Alternate Phone
Occupation	Occupation
Employer	Employer
Email	Email

Would you like appointment reminders by text? ☐ Yes ☐ No If Yes, who is your phone carrier: _____
Cell phone number: _____

Please Circle: MARRIED IN RELATIONSHIP SEPARATED DIVORCED
If parents are separated/divorced or do not reside together, please indicate custodial and/or living arrangements:

If parents are separated/divorced or not married, who has the legal responsibility for health insurance coverage:
Name: Phone:
Address: Relationship:

Primary Insurance		Policy Holder's Name
Policy Holder's DOB		Policy Holder's SS#
ID#	Group #	Effective Date

Please make sure Dr. Gloria Roetzer is listed as the child's Primary Care Provider

Secondary Insurance		Policy Holder's Name
Policy Holder's DOB		Policy Holder's SS#
ID#	Group #	Effective Date

* **PHARMACY** Name and Address:

Child Name Print on back for more blessings	DOB mm-dd-yyyy	Primary Language	Race	Ethnicity	Lives with: Circle all that apply
					Mother Father Guardian
					Mother Father Guardian
					Mother Father Guardian
					Mother Father Guardian
					Mother Father Guardian

List below any authorized individual(s) other than parent/guardian. (stepparents, grandparents, babysitters, etc.)

Name	Relationship	Phone #	Authorized to: **Circle all that apply**
			Schedule/attend appt. Make medical decisions Emergency Contact Receive/Provide medical and financial info.
			Schedule/attend appt. Make medical decisions Emergency Contact Receive/Provide medical and financial info.

Parent Signature: _____ Date_____

Who referred you to our office? _____

Trinity Pediatrics - Health History Form - Initial Visit

Child's Name:_____
Date of Birth_____

Your Name:_____
Relationship to Child:__ _____

Complications during pregnancy or birth?
Ever treated for or diagnosed with:
Please Circle all that apply.
Asthma Wheezing
Allergies: _____
Medication Allergies
Eczema
Recurrent Ear Infections
Pneumonia
Urinary Tract Infection
Seizures
Anemia
Other:_____
Current Medications and dose:_____
_____

Vitamins/ OTC medications: _____
Any feeding or dietary problems? Y / N
Who lives in the home?
# of Adults:____# of Children:____
Does child attend Daycare? Y / N
School performance concerns? Y / N
School Name:_____
Religious Preference: _____
Sports/Exercise _____
Screen time: _____hours/day
Pets: _____
Do any household members smoke? Y / N
Current smoke alarms/ CO_2 detectors? Y / N
Are firearms locked safely away from children?
No Firearms / Y / N

Family History: This is for the child, not the parent. Please indicate alive or deceased.

	Father	Mother	Paternal Grand father	Paternal Grand mother	Maternal Grand father	Maternal Grand mother	Sibling	Other
Asthma								
Allergy								
Anemia/ Blood disorder								
Cancer If yes, specify what type								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Stroke								
Diabetes: Type 1 or 2								
Thyroid Disease								
Migraines								
Mental Illness								
Alcohol/drug Abuse								
ADHD								
Other								