Providence Valley Young People's Clinic
1414 N. Vercler Road Bldg. #1
Spokane Valley, WA 99216
(509) 928-6383

PATIENT INFORMATION

Today's Date: _____ Referring Doctor: _____

Child's Name: _____ Birth Date: _____
(Last) (First) (M.I.)

Residence Address: _____
(Street) (City, State, Zip Code)

Residence Phone: _(_____)_____ Sex of child: _____ Child's S.S. # _____

Billing Information

Name of person responsible for bill:_____ SS#: _____

Billing Address: _____
(Street) (City) (State) (Zip Code)

Employer:_____ Business phone:_(_____)_____

Insurance Company:_____ Group/Sub. #: _____

Secondary Insurance:

Subscriber Name: _____ Employer: _____

Insurance Company: _____ Group/Sub. #: _____

Family Information

Birth Father's Name: _____ Date of Birth: _____ Business Phone _(_____)_____

Father's Employer: _____ Occupation: _____

Father's S.S. #: _____ Lives with this child ☐ Yes ☐ No ☐ Not Involved

Birth Mother's Name: _____ Date of Birth: _____ Business Phone: _(_____)_____

Mother's Employer: _____ Occupation: _____

Mother's S.S. #: _____ Lives with this child ☐ Yes ☐ No ☐ Not involved

Please list step-parents, siblings, extended family or friends who live in the home with this child:

Name	Relationship	Date of Birth

IMPORTANT – Will anyone other than a biological parent bring the patient to an appointment? If so, please complete the attached authorization on page 4.

Mark any of the following diseases that apply to this child's birth parents, brothers, sisters, grandparents, aunts, uncles, or first cousins.

- ☐ heart attacks before age 60
- ☐ strokes
- ☐ other heart disease
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ hay fever, allergies, or eczema
- ☐ asthma, TB, or other lung disease
- ☐ cystic fibrosis
- ☐ ulcers or other intestinal disease
- ☐ hepatitis
- ☐ diabetes
- ☐ kidney problems
- ☐ developmental delay or mental retardation
- ☐ seizures
- ☐ muscular dystrophy
- ☐ birth defects
- ☐ SIDS or other death at early age
- ☐ AIDS or other immune disease
- ☐ anemia or bleeding problems
- ☐ cancer
- ☐ mental illness
- ☐ drug or alcohol problems
- ☐ diseases that run in the family

NEW PATIENT HISTORY

Please provide as much medical history as possible. It will be part of your child's permanent medical record. Answer all you can, but don't worry about the ones you can't answer.

Person filling out the form: _____ Today's date: _____

Child's Medical History:

Does this child have any medical problems? ……☐ Yes ☐ No
Does he/she take any medications regularly?……☐ Yes ☐ No
Is this child allergic to any medications……☐ Yes ☐ No
Has this child ever had surgeries or been hospitalized? ……☐ Yes ☐ No
Has this child ever had any serious injuries (broken bones, unconsciousness)? ……☐ Yes ☐ No

Home/Social Environment:

Does anyone in the household smoke……☐ Yes ☐ No
Are there any handguns, rifles, or shotguns in the household? ……☐ Yes ☐ No
Does this child live near a swimming pool, pond, stream, or lake? ……☐ Yes ☐ No
Please list any pets: _____
Please explain any of the above: _____
_____
_____
_____

Mark any of the following that apply to this child now or in the past:

- ☐ frequent ear infections
- ☐ frequent tonsillitis or sore throats
- ☐ frequent sinus infections
- ☐ allergies or hay fever
- ☐ heart murmurs or defects
- ☐ cough, asthma, bronchitis or pneumonia
- ☐ diarrhea or constipation
- ☐ frequent abdominal pain or vomiting
- ☐ kidney or bladder infections
- ☐ skin problems
- ☐ muscle, bone, or joint problems
- ☐ frequent headaches
- ☐ fainting or passing out
- ☐ speech problems
- ☐ hearing problems
- ☐ vision problems
- ☐ seizures
- ☐ developmental delay or mental retardation
- ☐ breath holding
- ☐ temper tantrums
- ☐ toilet problems
- ☐ sleep problems
- ☐ problems in school or behavior problems

If this child is less than 1 year old:

Where born: _____ Birth Weight:_____

Mother's Obstetrician: _____

Any problems during pregnancy?……☐ Yes ☐ No
Any medications during pregnancy?……☐ Yes ☐ No
Did mother use drugs or drink alcohol during pregnancy?……☐ Yes ☐ No
Was the baby premature?……☐ Yes ☐ No
Any problems during the delivery?……☐ Yes ☐ No
Did the baby have to stay extra days in the hospital?. ……☐ Yes ☐ No

Nurse or bottle fed: _____If bottle, what formula? _____
Approximate age when started solids? _____

Please list the child's immunizations with dates if possible:

DTP #1_____	Polio#1_____	HIB #1_____	HBV #1_____	PCV #1_____
DTP #2_____	Polio #2_____	HIB #2_____	HBV #2_____	PCV #2_____
DTP #3_____	Polio #3_____	HIB #3_____	HBV #3_____	PCV #3_____
DTP #4_____	Polio #4_____	HIB #4_____	Menactra _____	PCV #4_____
DTP #5_____	MMR #1_____	Chicken Pox_____		
Tetanus_____	MMR #2_____			

Thank you very much for completing this health history, it will help us to provide the best medical care for your child.

Emergency Information

Name of nearest friend or relative not living with you:

Name: _____Phone:_(_____)_____Relationship:_____

Federally Required Patient Survey

What is your race?
Select one:
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Multiracial
□ Native Hawaiian or Other Pacific Islander:
□ White/Caucasian
□ Other: _____
□ Decline to answer

What is your gender? □ Male □ Female

What is your preferred language?
Select one:
□ American Sign Language
□ English
□ French
□ Korean
□ Mandarin-Cantonese
□ Mandarin - Chinese
□ Russian
□ Somali
□ Spanish
□ Vietnamese
□ Other: _____
□ Decline to answer

Do you consider yourself to be of Hispanic or Latino ethnicity?
Select one:
□ Yes
□ No
□ Decline to answer

Signed_____ Date: _____
Parent or Guardian

**********Please Do Not Write Below This Line – For Clinic Use Only**********

Reviewed by: _____ Date: _____

Description for use of this form: Our office can only provide treatment to a patient with a natural parent or legal guardian's written permission. If you anticipate that anyone, including a stepparent, grandparent, babysitter, etc., may bring your child for a medical visit, please complete this form with your name, the child's name, the name of the individual who may accompany your child for medical care, sign, date, and provide contact numbers where you may be reached. Ask the receptionist if you need additional forms for other children or additional care givers. If you have any questions or concerns our receptionists will be happy to assist you.

Medical Treatment Consent Form

I, _____, Mother/Father/Legal Guardian of _____ authorize _____ to seek and authorize treatment for medical care including immunizations and any emergent procedures provided by Providence Valley Young People's Clinic. I also understand and agree that this consent shall remain in effect until revoked by me in writing.

_____ _____

Signature of Mother/Father/Legal Guardian Date

_____

Phone number where I can be contacted

Account Number_____