GAGON FAMILY PRACTICE

NEW PATIENT INFORMATION FORM

Please Print

Name: _____ Birth Date: _____ Sex: __ M __ F

Address: _____City/State/ Zip: _____

SS# _ _ _- _ _ - _ _ _ _ Marital Status: _____ Email address: _____

Home Phone # (_ _ _) _ _ _- _ _ _ _ Cell Phone# (_ _ _) _ _ _-_ _ _ _ Work Phone# (_ _ _) _ _ _- _ _ _ _

Are you a student: Yes _____ No _____ Full Time: _____ Part Time: _____

Employer: _____ Full Time: _____ Part Time: _____

Emergency Contact (Not living with you):

Name: _____ Relationship: _____ Phone#: (_ _ _) _ _ _-_ _ _ _
Name: _____ Relationship: _____ Phone#: (_ _ _) _ _ _-_ _ _ _

Appointment Reminder Call Contact # (please circle one) ***Home*** ***Cell***

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Native Hawaiian or Other Pacific Islander ☐Hispanic or Latino ☐Other ☐Unreported/ Refused to Report

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Refused to Report

Preferred Language: ☐English ☐Indian ☐Spanish ☐Russian ☐Other _____

RESPONSIBLE PARTY INFORMATION

Name: _____Date of Birth: _____ SS# _ _ _- _ _-_ _ _ _

Address: _____City/State/Zip: _____

Home Phone # (_ _ _) _ _ _-_ _ _ _ Cell Phone# (_ _ _) _ _ _ - _ _ _ _

Relationship to patient: _____

Please list names of all family household members that are seen in our office:

Name: _____ DOB: _____ Name: _____ DOB_____

Name: _____ DOB: _____ Name: _____ DOB: _____

How did you hear about us? ☐Radio ☐Newspaper ☐Website ☐Referral ☐Other _____

PLEASE PROVIDE THE RECEPTIONIST YOUR INSURANCE CARD(S)

We will need to make a copy at each appointment to insure correct billing. Thank you!

GAGON FAMILY PRACTICE

Name _____

Health History Form for NEWBORN Patients (0-6 Months)

Welcome to our practice! To provide your newborn with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Birth Weight: _____ **Birth Length: _____**

Any complications with pregnancy or delivery? Y N If yes why? _____

_____

Has this child been hospitalized since birth? Y N If yes why? _____

_____

Has this child had any surgery? Y N If yes why? _____

_____

This child has been: (Please circle one) Breast Fed Bottle Fed Both

Please list all currently used medications, include doses and non prescription drugs:

_____

_____

Does this child have any known allergies?

Allergic to: _____

Reaction: _____

Please list any immunizations since birth:

_____

_____

Has any blood relative had:

	Yes	No	Relationship to patient?				
Diabetes	**Y**	**N**	**_____**	**Asthma**	**Y**	**N**	**_____**
Alcoholism	**Y**	**N**	**_____**	**Ulcers**	**Y**	**N**	**_____**
Tuberculosis	**Y**	**N**	**_____**	**Cancer**	**Y**	**N**	**_____**
Birth Defects	**Y**	**N**	**_____**	**Stroke**	**Y**	**N**	**_____**
Epilepsy or Seizures	**Y**	**N**	**_____**	**Suicide**	**Y**	**N**	**_____**
Heart Trouble	**Y**	**N**	**_____**				
Mental Illness	**Y**	**N**	**_____**				
Severe Allergies	**Y**	**N**	**_____**				
Glaucoma	**Y**	**N**	**_____**				
High blood pressure	**Y**	**N**	**_____**				