



Patient name: _____

MRN: _____

The government mandates that all healthcare is provided fairly, without regard to race or ethnicity. These registration questions are to insure we are meeting these guidelines. This information will be kept confidentially.

Race

- American Indian/Alaskan Native
- Asian Indian
- Black, African American
- Caucasian (White)
- Chinese
- Filipino
- Guamanian/Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Samoan
- Vietnamese
- Unknown
- Decline

Preferred Language

- English
- Spanish
- Arabic
- Chinese (all types)
- French
- German
- Greek
- Italian
- Japanese
- Korean
- Navajo
- Polish
- Russian
- Tagalog
- Ukrainian
- Vietnamese
- Other(Specify) _____

Ethnicity

- Cuban
- Mexican/ Mexican American
- Other Hispanic/Lantino/a or Spanish Origin
- Puerto Rican
- Non Hispanic/Latino/a or Spanish Origin
- Unknown
- Decline

Interpreter Services Needed: YES NO

Veteran Status

- No, Currently Serving branch _____
- No, Never Serviced
- Yes
- Yes Combat veteran
- If YES, Branch of Service _____

Marital Status:

- Married
- Divorced
- Legally Seperated
- Single
- Widowed
- Significant Other
- Other

Emergency Contact

Name _____

Phone _____

Relationship: _____

Currently employed Yes No

If YES, Employer _____

Patient Email: _____

Do you want to sign up for MY CHART -online access to your Medical Records? YES NO

Patient(or Guardian) Signature: _____ **Date:** _____

Patient Name:		Birth Date	Age	M	F
Mother's Name:	Father's Name:	Forms Completed By:		Date	

Household Information

Name	Relation to Child	Birth Date	Health Problems	Occupation

Social History

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

Does the child have access to a pool? Is it fenced or covered? ()yes ()no
Explain. _____

What languages are spoken in home? () English
() Spanish () Other _____

Childcare? () Parents () Relatives () Daycare
() Babysitter/Nanny

Days per week at daycare (not with parents). ___

Do any household members smoke? ()yes ()no

Birth History

Did mother have any illness or problems with pregnancy? ()yes ()no Explain _____

During the pregnancy did mother use medications, drugs, smoke or drink alcohol?
()yes ()no Explain _____

Was the delivery () Vaginal? () C-section?

Was the baby () Term? () Early?

Gestational Age? ___ weeks

What was the baby's birth weight ___ lbs ___ oz

Did your baby have any problems right after birth?
()yes ()no Explain _____

Did your baby pass the hearing screen?
()yes ()no Explain _____

Did your baby get the Hepatitis B vaccine?
()yes ()no Explain _____

Did your baby go home with mother from the hospital? ()yes ()no Explain _____

General Information

Does your child see any specialists?
()yes ()no Explain _____

Does your child have any serious illness or medical condition?
()yes ()no Explain _____

Has your child had any serious injuries or accidents?
()yes ()no Explain _____

Has your child had any surgeries?
()yes ()no Explain _____