

OAK TREE PEDIATRICS AND MORE

WELCOME AND THANK YOU FOR COMING TO SEE US!

Family Last Name(s) _____ Date _____

Siblings (Name/DOB) _____ (Name/DOB) _____

Siblings (Name/DOB) _____ (Name/DOB) _____

Address _____ Phone# _____ Cell# _____

City _____ State _____ Zip _____

Mother's Name _____ DOB _____ SS# _____

Employed by _____ Phone# _____ Driver's Lic# _____

Father's Name _____ Cell # _____ DOB _____ SS# _____

Employed by _____ Phone# _____ Driver's Lic# _____

Who referred you to our office? _____

Nearest Relative NOT Living With You _____ Relationship _____

Address _____ State _____ Phone _____

Family History: Please fill in as completely as possible if ANY relative has had the following:

Y/N Kidney Trouble	Y/N Birth Deformities	Y/N Asthma	Y/N Foot Problems	Y/N Anemia
Y/N Mental Illness	Y/N Hayfever Y/N	Y/N Migraine	Y/N Urine Infection	Y/N Colic
Y/N Thyroid Trouble	Y/N Skin Disease	Y/N Easy Bleeding	Y/N Heart trouble	Y/N Hearing Loss
Y/N Cancer	Y/N High Blood Pressure	Y/N Diabetes Y/N	Y/N Ear trouble	Y/N Muscle Disease
Y/N Ulcers	Y/N Arthritis	Y/N Eye Problems	Y/N Liver Disease	Y/N Hives
Y/N Retarded Children	Y/N Convulsions	Y/N Allergy	Y/N Lung Disease	Y/N Nervous Disease
Y/N Bone Disease	Y/N Breathing Problems	Y/N Colitis	Other _____	

Drug Allergies: _____

INSURANCE INFORMATION: * Please give card to the receptionist to copy. *

Name of Insured _____ Policy # _____

Insurance Company _____ Group # _____

Primary Care Physician _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE BELOW.

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Driver's Lic # _____

SS# _____ Employer _____

By the signature below, I hereby certify the correctness of the above information and authorize release of information to my insurance company. I assign benefits to Oak Tree Pediatrics and More, Dr. Spadaro, Dr. Weisz, or Dr. Spinner. A photocopy of the assignment may serve as the original. I hereby agree that in consideration for services rendered by the doctor(s), I shall make prompt payment to my account as bills are presented. If it becomes necessary for the account to be referred to collective action, I shall pay the actual attorney's fees and collection expenses.

Signed _____ Date _____

Patient or Responsible Party