Aruna D Poduval, MD
Pediatric Endocrinologist

Francine Marran, RN, CDCES
Registered Nurse, Certified Diabetes Educator

New Patient Registration Form

Who is accompanying the patient today?_____ Relationship to patient:_____ Do you have legal decision making power?_____

Last Name:_____ First Name:_____ Middle Initial:_____
Sex:____Male_____Female Date of Birth:_____ SS#:_____ Street Address:_____ City:_____ State:_____
Zip Code:_____ Work Phone:_____ Mobile Phone:_____
Home Phone:_____ Race(Check One)_____IndianAmerican/AlaskanNative _____Asian/Oriental_____Black/African American_____Native Hawaiian/Pacific Islander_____White_____Other_____Declined Ethnicity(Check One)
Central American_____Cuban____Dominican_____Hispanic/Latino_____Mexican_____Puerto Rican_____ South American_____Spainard_____Not Hispanic/Latino_____Other____Declined
Marital Status:____Single_____Married____Other(Widow,Divorced,Separated)
Spouses Name:_____ Spouses Employer:_____
Phone:_____ E-Mail Address:_____
Patient PCP:_____ Patient Referred By:_____
Preferred Pharmacy (Location& Phone Number)_____

Guardian Information(If Applicable)
Last Name:_____ First Name:_____ Middle Initial:_____
Date of Birth:_____ Street Address:_____ City:_____ State:_____
Zip Code:_____
Phone #:_____ SS#_____ Employer:_____
Employer Address:_____ Employer Phone:_____

Emergency Contact Information
Last Name:_____ First Name:_____ Phone #:_____
Relationship to Patient:_____

Employer Information
Employer Name:_____ Employer Phone Number:_____
Address:_____ City:_____ State:_____
Zip Code:_____

Guarantor Information
Last Name:_____ First Name:_____ Middle Initial:_____
Phone#:_____ SS#:_____ Date of Birth:_____
Street Address:_____ City:_____ State:_____ Zip Code:_____
Employer Name:_____ Employer Address:_____ Employer #:_____

Insurance Information
Insurance Plan Name:_____ Insurance Phone #:_____
Policy ID#:_____Policy Group#:_____

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Medical History Form

Name:	**DOB:**

PLEASE CIRCLE ALL THAT APPLY

Adrenal Disease	Y	N	Headaches/Migraine	Y	N
Allergies	Y	N	Hearing Loss	Y	N
Anemia	Y	N	Heart Disease	Y	N
Asthma	Y	N	Heart Rhythm Disorder	Y	N
Autoimmune Disease	Y	N	Hypertension	Y	N
Blood Disorder	Y	N	Hyperlipidemia	Y	N
Bone/Calcium Disorder	Y	N	Kidney Disease/Stones	Y	N
Coronary Artery Disease	Y	N	Liver Disease/Hepatitis	Y	N
Developmental Disorders	Y	N	Lung Disease	Y	N
Depression	Y	N	Menstrual Disorder	Y	N
Diabetes, Type 1 or 2	Y	N	Mental Illness	Y	N
Diabetic Complications	Y	N	Nerve Disease	Y	N
Endocrine Disease	Y	N	Osteopenia/Osteoporosis	Y	N
Eye Problems	Y	N	Overweight/Obesity	Y	N
Failure to Thrive	Y	N	Pituitary Disease	Y	N
Gastritis/Ulcer	Y	N	Pneumonia	Y	N
GERD/Acid Reflux	Y	N	Polycystic Ovarian Syndrome (PCOS)	Y	N
Pre-Diabetes	Y	N	Underweight	Y	N

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Premature Birth	Y	N	Urinary Problem	Y	N
Pubertal Disorder	Y	N	Viral Disease	Y	N
Thyroid Disease	Y	N	Palpitations	Y	N
Tuberculosis (or Positive TB Test)	Y	N	Vascular Heart Disease	Y	N
Turner Syndrome	Y	N	Other:	Y	N

Past Surgical History

Surgery	Reason	Year	Hospital

Current Medications

Drug Name	Strength	Frequency Taken

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Allergies to Medications

Please List:

Family Health History

Relation	Health Problem	Age At Death	Cause of Death

Social History

Tobacco	**Do you use Tobacco? Y or N?** **Have you used Tobacco in the past? Y? or N?** **How Long? Year Quit:** **How many Cigarettes/day?__ Chew __ Cigars__**
Diet	**Regular __ Vegetarian __ Vegan __ Gluten Free __ Carbohydrate __**
Exercise Level	**None __ Occasional __ Moderate __ Heavy __**
Parent's Marital Status	**Married__ Divorced __ Unmarried __ Separated __ Widowed __**
Home Situation	**Both Parents __ Mother __ Father __ Relatives __ Adoptive Parents __ Foster Parents __ Other _____**
Siblings (How Many)	**Brothers ___ Sisters ___**
Year in School (Pre-K-College)	**_____**