Noah's Ark Pediatrics Patient Demographics & Medical History

17560 N. 75th Avenue, Suite 400 Glendale, AZ 85308

Today's Date:	**Email:**	Gender: ☐ Male ☐ Female
Patient's Name:		Date of Birth: / /
Name of the person completing this form:		Relationship to Patient:
Contact/Legal Guardian Name:		Mother: ☐ Father: ☐ Other: ☐
Address:		Phone #:
City: State: Zip:		Relationship to Patient:
In Case of Emergency: Phone #:		Relationship to Patient:

PATIENT LIVING WITH

Lives with parents: ☐ Yes ☐ No	Number of brothers:	Number of sisters:
Step / adopted family: ☐ Yes ☐ No	Relatives (not parents or siblings) ☐ Yes ☐ No	How many?
Partner: ☐ Yes ☐ No	Foster Home: ☐ Yes ☐ No	Group Home: ☐ Yes ☐ No
Exposed to cigarette smoke at home: ☐ Yes ☐ No	Guns at home: ☐ Yes ☐ No	Pets or other animals: ☐ Yes ☐ No

PATIENT'S EDUCATION

Daily care of child:	Currently in school: ☐ Yes ☐ No	Which grade:
School is : ☐ Public ☐ Private ☐ Home	Having difficulty: ☐ Yes ☐ No	Excelling: ☐ Yes ☐ No
Tobacco use: ☐ Yes ☐ No	Alcohol use: ☐ Yes ☐ No	Drug use: ☐ Yes ☐ No

PATIENT'S INSURANCE INFORMATION (Must have CURRENT copy of Insurance Card/Information)

Primary Ins. Name:	Member ID:	Group ID:
Insurance Company:	Mailing Address:	Phone #:
Policy Holder Name:	Policy Holder DOB:	Relationship to Patient:
Secondary Ins. Name:	Member ID:	Group ID:
Insurance Company:	Mailing Address:	Phone #:
Policy Holder Name:	Policy Holder DOB:	Relationship to Patient:

PATIENT'S MEDICAL HISTORY

Abuse / Neglect:	☐	Chickenpox	☐	Fracture	☐
ADD / ADHD	☐	Concussion	☐	Headache	☐
Allergic Rhinitis	☐	Congenital Heart Disease	☐	Mental Illness	☐
Anemia	☐	Constipation	☐	Migraines	☐
Asthma	☐	Developmental-Mental Retardation	☐	Pneumonia	☐
Bed wetting	☐	Diabetes	☐	Seizure Disorder	☐
Blood Disorder	☐	Eczema	☐	Speech difficulty	☐
Cancer	☐	Febrile Convulsions	☐	Tuberculosis	☐
Cerebral palsy	☐	Frequent Ear Infections	☐	Urinary Tract Infections	☐

PATIENT'S SEXUAL ACTIVITY

Sexually active: ☐ Yes ☐ No	Do you use condoms or any other birth control? ☐ Yes ☐ No

PATIENT FAMILY HISTORY

Does any family member have any of the following medical conditions? If yes, please explain and state the relationship (i.e. uncle, cousin, maternal grandfather).

Alcoholism	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Blood Disorder	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Seizure Disorder	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Thyroid Disorder	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No		

Patient / Parent / Guardian Signature_____ Date: _____