

PEDIATRIC AFFILIATES, P.A.
SPECIALIZING IN INFANTS, CHILDREN, & ADOLESCENT MEDICINE

To ensure that we have the most current information on our patients, please take a minute to answer the following questions.

Patient Name: _____ **Date of Birth:** ____ / ____ / ____

What is the race of the patient? (Check any that apply)

- | | |
|--|---|
| _____ American Indian or Alaska Native | _____ Native Hawaiian or Other Pacific Islander |
| _____ Asian | _____ White |
| _____ Black or African American | _____ Refused to Report / Unreported |

What is the ethnicity of the patient?

- | | |
|------------------------------|--------------------------------------|
| _____ Hispanic or Latino | _____ Refused to Report / Unreported |
| _____ Not Hispanic or Latino | |

What is the primary language of the patient? _____

What is your preferred notification method? _____ Phone _____ Postal Mail

What is your preferred pharmacy? Name: _____

Address: _____ **City:** _____

Does the patient take any regularly prescribed medications? _____ Yes _____ No
If yes, please list them.

Medication Name	Strength	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the patient have any allergies (including food, medication and environmental)?

_____ Yes _____ No If yes, please list them. _____

Does the patient have any chronic conditions? _____ Yes _____ No. If yes, please explain.

If the patient is 13 years or older, does he/she smoke? _____ Yes _____ No

Signature (Parent / Guardian) _____ **Date** ____ / ____ / ____