Lincoln Pediatric Group, LLC
Family Registration

Date _____ Physician _____

LIST BIOLOGICAL/ADOPTIVE PARENTS:

MOTHER _____ Marital Status: ○ Single ○ Married ○ Divorced

Birth Date _____ Address _____ City _____ State ____ Zip _____

Cell Phone ( ) _____ Work Phone ( ) _____ Home Phone ( ) _____

Employer _____ Email _____

FATHER _____ Marital Status: ○ Single ○ Married ○ Divorced

Birth Date _____ Address _____ City _____ State ____ Zip _____

Cell Phone ( ) _____ Work Phone ( ) _____ Home Phone ( ) _____

Employer _____ Email _____

LIST ALL CHILDREN:

	BIRTH DATE	*SEX*	*LIVES WITH:*	*RELATIONSHIP:*
Name _____	_____	_____	○ Mom ○ Dad	○ Biological ○ Non-biological
Name _____	_____	_____	○ Mom ○ Dad	○ Biological ○ Non-biological
Name _____	_____	_____	○ Mom ○ Dad	○ Biological ○ Non-biological
Name _____	_____	_____	○ Mom ○ Dad	○ Biological ○ Non-biological

List any deceased children: Name _____ Cause of death _____

IF ANY CHILDREN HAVE A PARENT OTHER THAN THE ONE(S) LISTED ABOVE, PLEASE ADD:

Name _____ Child's Name _____

Birth Date _____ Address _____ City _____ State ____ Zip _____

Cell Phone ( ) _____ Work Phone ( ) _____ Home Phone ( ) _____

Employer _____ Email _____

EMERGENCY CONTACT OTHER THAN PARENTS:

Name _____ Relationship _____ Phone ( ) _____

WHO REFERRED YOU TO OUR OFFICE? _____

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH OCCUR IN ANY RELATIVE AND STATE THE RELATIONSHIP TO THE CHILD *(PLEASE SPECIFY MATERNAL OR PATERNAL)*:

○ **No changes since last form completed**

DISEASE	*MATERNAL*	*PATERNAL*	*RELATIONSHIP TO CHILD:*
○ Asthma	○	○	
○ Hay Fever/Allergies	○	○	
○ Eczema	○	○	
○ Lead Poisoning	○	○	
○ Blood or Bleeding Disease	○	○	
○ Epilepsy/Convulsions	○	○	
○ Kidney Disease	○	○	
○ Developmental Disabilities	○	○	
○ Nervous Condition	○	○	
○ Diabetes	○	○	
○ Cancer	○	○	
○ Depression	○	○	

DISEASE	*MATERNAL*	*PATERNAL*	*RELATIONSHIP TO CHILD:*
○ Tuberculosis	○	○	
○ Stillborn Babies	○	○	
○ Miscarriage	○	○	
○ Other Inherited Disease	○	○	
○ Hearing Loss/Deafness	○	○	
○ Thyroid Disease	○	○	
○ High Blood Pressure	○	○	
○ Birth Defects	○	○	
○ Heart Disease	○	○	
○ High Cholesterol	○	○	
○ Alcoholism	○	○	
○ None of the above	○	○	

Does anyone smoke in the home? ○ Yes ○ No

I hereby authorize The Lincoln Pediatric Group to release any information acquired in the course of examination to my insurance carrier. This authorization shall remain valid until written notice is given by me revoking said authorization. I further authorize payments directly to the physician. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature _____ Date _____

Print Name _____