FAMILY INFORMATION SHEET

Family Last Name: _____ **Doctor:** _____

Race: _____ **Ethnicity: (Hispanic / Not Hispanic) Language:** _____

Child's Address_____
Street City Zip

Father/Parent: _____ **DOB**: _____
Home Phone Number:_____Cell Phone Number: _____
Work Phone Number: _____
Parent's Address: _____
Street City Zip
Employer: _____ Occupation: _____
AHP Network or GRIPA
Father/Parent's e-mail: (list only if OK to use) _____

Mother/Parent: _____**DOB:**_____
Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____

Parent's Address: _____
Street City Zip
Employer: _____ Occupation: _____
AHP Network or GRIPA
Mother/Parent's e-mail: (list only if OK to use) _____

Preferred Pharmacy (please be specific (address))_____

Emergency Contact (other than parents):_____ Phone: _____

Parent Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐ Separated ☐Partners

Child's First Name	Last Name	Date of Birth	Health Problems Drug Allergies	e-mail address

I authorize payment of medical benefits to the above named physician. I also agree to the release of any pertinent medical information necessary to expedite insurance payment. I also authorize insurance companies to review my health record for quality reporting.

Signed: _____ **Date:** _____

FAMILY HISTORY SHEET

Family Last Name: _____ Doctor: _____
Each Child's First Name in Family: _____
_____

Other Heath Care Providers (for the children, not the parents):

FULL Name of Provider: For which Children:

Dentist: _____

OB/GYN :_____

Behavioral Health: _____

Endocrinologist: _____

G.I.: _____

Other: _____

Other: _____

Family History (as pertains to your child. i.e.: if you as the mom have allergies, fill in MOM under WHO)

☐ **UNKNOWN / ADOPTED** ☐ **No Significant Family History**

(parents, siblings, grandMOM, grandDAD, aunts/uncles)

☐	**Alcoholism:**	**who:** _____	☐	**Hypercholesterolemia:**	**who:** _____
☐	**Allergies:**	**who:** _____	☐	**Hypothyroidism:**	**who:** _____
☐	**Alzheimer's Disease:**	**who:** _____	☐	**Inflam. Bowel Disease:**	**who:** _____
☐	**Anemia:**	**who:** _____	☐	**Irritable Bowel Synd.:**	**who:** _____
☐	**Anxiety:**	**who:** _____	☐	**Kidney Disease:**	**who:** _____
☐	**Arthritis:**	**who:** _____	☐	**Liver Disease:**	**who:** _____
☐	**Asthma:**	**who:** _____	☐	**Mental Illness:**	**who:** _____
☐	**ADHD:**	**who:** _____	☐	**Myocardial Infarction:**	**who:** _____
☐	**Autism:**	**who:** _____	☐	**Obesity:**	**who:** _____
☐	**Bedwetting:**	**who:** _____	☐	**Renal Failure:**	**who:** _____
☐	**Cancer:**	**who:** _____	☐	**Smoking:**	**who:** _____
☐	**Celiac Disease:**	**who:** _____	☐	**Substance Abuse:**	**who:** _____
☐	**Depression:**	**who:** _____	☐	**Thyroid Disease:**	**who:** _____
☐	**Diabetes:**	**who:** _____	☐	**Tuberculosis (TB):**	**who:** _____
☐	**Down Syndrome:**	**who:** _____	☐	**Other:**	**who:** _____
☐	**Epilepsy:**	**who:** _____	☐	**Other:**	**who:** _____
☐	**Hearing Loss:**	**who:** _____	☐	**Other:**	**who:** _____
☐	**Heart Disease:**	**who:** _____	☐	**Other:**	**who:** _____

Smoking in Family:

☐ **No** ☐ **Quit** ☐ **Yes** **who: _____**

Signed: _____ Date: _____