



The Lincoln Pediatric Group, LLC Family Registration

Date _____

Physician _____

Mother _____ Marital Status: Single Married Divorced
 Birth Date _____ Address _____ City _____ State _____ Zip _____
 Cell Phone(____) _____ Work Phone(____) _____ Home Phone(____) _____
 Employer _____ SS# _____

Father _____ Marital Status: Single Married Divorced
 Birth Date _____ Address _____ City _____ State _____ Zip _____
 Cell Phone(____) _____ Work Phone(____) _____ Home Phone(____) _____
 Employer _____ SS# _____

LIST ALL CHILDREN:

Name	Birth Date	Sex	Lives with	Relationship
_____	_____	_____	mom/dad	biological/non-biological
_____	_____	_____	mom/dad	biological/non-biological
_____	_____	_____	mom/dad	biological/non-biological
_____	_____	_____	mom/dad	biological/non-biological
_____	_____	_____	mom/dad	biological/non-biological

List any deceased children: Name _____ Cause of death _____

IF ANY CHILD HAS A BIOLOGICAL PARENT OTHER THAN LISTED ABOVE, PLEASE ADD:

Name _____ SS# _____ Child's Name _____
 Birth Date _____ Address _____ City _____ State _____ Zip _____
 Cell Phone(____) _____ Work Phone(____) _____ Home Phone(____) _____
 Employer _____ Relationship to child _____

EMERGENCY CONTACT OTHER THAN PARENTS:

Name _____ Relationship _____ Phone (____) _____
 Who referred you to our office? _____

CHECK ANY OF THE FOLLOWING CONDITIONS THAT OCCUR IN ANY RELATIVE AND STATE THE RELATIONSHIP TO THE CHILD

Disease	Relationship to child	Disease	Relationship to child
<input type="checkbox"/> Asthma		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Hayfever/Allergies		<input type="checkbox"/> Stillborn babies	
<input type="checkbox"/> Eczema		<input type="checkbox"/> Miscarriage	
<input type="checkbox"/> Lead Poisoning		<input type="checkbox"/> Other inherited disease	
<input type="checkbox"/> Blood or bleeding disease		<input type="checkbox"/> Hearing loss/Deafness	
<input type="checkbox"/> Epilepsy/Convulsions		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Kidney disease		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Mental retardation		<input type="checkbox"/> Birth defects	
<input type="checkbox"/> Nervous condition		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> High cholesterol	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Alcoholism	
<input type="checkbox"/> Depression		<input type="checkbox"/> 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 _____