Sugarloaf Urgent Care | 4835 Sugarloaf Parkway Suite 200 | Lawrenceville, GA 30044 |
Phone: 470-375-5940 | Fax: 470-375-5952 | Website: www.sugarloafurgentcare.com

Minor Child - New Patient Application

Child: Last Name__________________________ First Name _____________________________

Date of Birth _____________________ Age ____________________

Child's Current / Previous PCP: ____

Normal Birth: _____ (Y) _____ (N) – If no, please explain: ________________________________

____

____

Is this your child by:

- o Birth
- o Adoption
- o Step-child
- o Other: _________________

Birth Weight: ___________________. What city or State was your child born in? ___________

Was your baby premature? _____(Y) _____ (N)

Any problem during pregnancy? _____(Y) _____ (N)

Where there any significant complications during labor and delivery? _____ (Y) _____ (N)

If yes, please explain: ____

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____

Growth & Development

Have you or your prior pediatrician had any concerns about your child's growth or development? (speech | language | social skills | motor skills | etc…) _____(Y) _____(N)

Past Medical History

Has your child:

- Had any serious medical illness? _____ (Y) _____(N)
- Had a history of asthma or wheezing? _____(Y) _____ (N)
- Had any minor or major surgery? _____(Y) _____ (N)
- Ever used a nebulizer or an inhaler? _____ (Y) _____ (N)
- Had any broken bones? _____ (Y) _____ (N)
- Had any mental / behavioral problems? _____ (Y) _____ (N)
- Had a positive tuberculosis skin test? _____ (Y) _____ (N)
- Been hospitalized overnight? _____(Y) _____ (N)

  If yes, to any of the above, please explain: ____

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Immunizations

- Is your child up to date with their vaccination? _____ (Y) _____ (N)
- Have you refused any vaccines for your child? _____ (Y) _____ (N)

  If yes, to any of the above, please explain: ____

  ____

  ____

Medications

Please list any current medications (vitamins | supplements | over the counter | etc…)

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

Allergies

Please list any allergies and reactions to: medications | vaccines | foods | stings | etc…

ALLERGY	REACTION

Emergency Contact & Medical Information For Child

Parent / Guardian Name ______________________________

Street Address ______________________________ Apt ____________

City ____________________ State ____________ Zip Code ____________

Home Phone ________________ Cell Phone ________________

Email Address ______________________________

Alternative Emergency Contacts

Primary Emergency Contact Name ______________________________

Street Address ______________________________ Apt ____________

City ____________________ State ____________ Zip Code ____________

Home Phone ________________ Cell Phone ________________

Medical Information

Hospital / Clinic Preference ____

Physician's Name __________________________ Phone Number ________________

Insurance Company _______________________ Policy Number _________________

Allergies / Special Health Considerations______________________________________

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I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

____ ________________________

Parent / Guardian Signature Date