SOUTHERN COOS HOSPITAL & HEALTH CENTER

Quality Healthcare With a Personal Touch

Patient Registration Form – Child

Patient Demographic Information

Patient Name: (Last, First, M.I.)	Social Security Number: ___ – ___ – ____	Preferred Name:

Date of Birth: (M / D / YY)	Sex at Birth: ☐Male ☐Female	Gen. Identity:	Ethnicity: ☐Non-Hispanic/Latino/Latina ☐Hispanic/Latino/Latina

Parent's Marital Status:	Patient Lives With:	Race:
☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partner	☐Both Parents ☐Father ☐Mother ☐Other:	☐White ☐Asian ☐Native American ☐Alaskan Native ☐African American ☐Native Hawaiian ☐Pacific Islander ☐More than one race ☐Other:

Communication Preferences

Phone: ☐Home ☐Cell ( ) -	Email Address:

Preferred Communication Method: ☐MyChart ☐Text Message ☐Phone Call ☐Email ☐Other:

Preferred Emergency Contact Name:	Relationship to Patient:	Emergency Phone Number: ( ) -

Immediate Family Information

Name:	Relationship to Patient: ☐Father ☐Mother ☐Other:	Phone Number: ( ) -

Home Address: City: State: Zip:

Name:	Relationship to Patient: ☐Father ☐Mother ☐Other:	Phone Number: ( ) -

Home Address: City: State: Zip:

Mailing Address: City: State: Zip:

Are you self-pay / uninsured? ☐No ☐Yes (skip to next page)

Primary Insurance Company:	Policy/Member ID Number:	Policy Group Number:

Policy Holder Name:	Policy Holder DOB:	Policy Holder Social Security Number:

Secondary Insurance Company:	Policy/Member ID Number:	Policy Group Number:

Policy Holder Name:	Policy Holder DOB:	Policy Holder Social Security Number:

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Health History – Child

Patient Name:_____ Date of Birth:_____ Today's Date:_____

Immunization Information

A printed copy of your immunization history is needed before you see a doctor
Please use this time to call your previous doctor and request your immunization records

☐ Immunization history will be dropped off at the front desk soon ☐ Immunization history will be brought at first visit

☐ Patient is fully up-to-date on immunizations ☐ Patient is behind on immunizations ☐ Patient declines immunizations

Current Doctors / Providers / Specialists

Are you transferring from out of state? ☐No ☐Yes, I am transferring from (city, state):

Provider Type	Provider and Facility Name	Provider Type	Provider and Facility Name
Primary Doctor		Physical Therapy	
Cardiologist (Heart)		Psychiatrist/Counselor	
Gastroenterologist (Stomach)		Pulmonologist (Lung)	
Oncologist/Hematologist (Cancer)		Social Worker/Case Worker	
Other:		Urologist (Kidney/Bladder)	

Current Medications:

List all prescriptions, over the counter, and any other medications that you currently take.
Please include any herbal or nutritional supplements, inhalers, eye drops, ointments, etc.

Preferred Pharmacy and Location:

Medication	Dose	Frequency
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:

Allergy Information

☐No Known Allergies ☐Medications ☐Tape/Adhesive (band-aids) ☐Latex ☐Food ingredient (gluten, lactose, etc.)

Allergen	Reaction	Allergen	Reaction

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Surgical History

Operation/Procedure (bilateral, left, right, etc.)	Date	Reason	Hospital/Facility

Current Medical Concerns (not past history):

List your current complaints, conditions, and concerns

Examples: Strep throat, ADHD, etc.	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term

Past Medical History:

List any significant medical conditions that have already been treated

Examples: Dandruff, concussion, etc.

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Family Medical History:

Mark any family member who has experienced any of the following conditions

☐ Patient is adopted, unknown family history ☐ Patient is a twin/triplet

Condition	Mother	Father	Sister(s)	Brother(s)	Child(ren)	Grandmother	Grandfather
Arthritis	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Cancer (specify)	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Depression	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Diabetes	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Heart Disease	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
High Blood Press.	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Kidney Disease	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Stroke/TIA	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Substance Abuse	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Other:	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal

Social History

Exercise Routine:	☐Running ☐Sports ☐Other:	Days per Week:	Minutes of Exercise:
Nicotine Use:	☐Cigarettes ☐Smokeless Tobacco (chew, pouch, etc.) ☐Vaping/Electronic ☐Other:		
Frequency:	☐Never ☐Daily ☐Some Days	Usage Dates: From _____ to _____	
Number of Packs/Pouches per Day: ☐0.25 ☐0.5 ☐1 ☐2 ☐Other:			
Vape Use:	☐Nicotine ☐THC ☐CBD ☐Other:		
Frequency:	☐Never ☐Daily ☐Some Days	Usage Dates: From _____ to _____	
Number of Cartridges per Day: ☐0.25 ☐0.5 ☐1 ☐2 ☐Other:			
Alcohol Use:	☐Wine ☐Beer ☐Liquor ☐Other:	Num of Drinks per Sitting: ☐1-2 ☐3-4 ☐5-6 ☐6+	
Frequency:	☐Never ☐2-4 Times per Month ☐2-3 Times per Week ☐4+ Times per Week ☐Alcoholic		
Sexual Activity:	Are you sexually active? ☐Yes ☐No	Partner(s): ☐Male ☐Female	
Birth Control:	☐None ☐Condom ☐Pill ☐Patch ☐I.U.D ☐Injection ☐Other:		

Women's Health History

Age Period Began: ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15	Are your Periods Regular each month? ☐Yes ☐No	
Number of Pregnancies: ☐0 ☐1 ☐2 ☐3	Number of Live Births:	Number of Miscarriages/Abortions: