Tracey L. Brennan, M.D. 324 West Ave., Saratoga Springs, NY 12866

For internal use only
Patient Account #_____

PATIENT REGISTRATION

Date_____

PATIENT INFORMATION

FIRST NAME_____MIDDLE_____LAST NAME_____

DATE OF BIRTH _____ SEX_____SOCIAL SECURITY # _____

HOME ADDRESS_____ CITY_____STATE_____ZIP_____

MAILING ADDRESS _____ CITY_____STATE_____ZIP_____

HOME PH. # (_____) _____

WORK PH. # (_____) _____CELL PH# (____)_____

EMAIL _____ Would like access to the Patient Portal through EMR system ____ YES ____ NO

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed

RACE: _____ HISPANIC OR LATINO DECENT ____ YES ____ NO PRIMARY LANGUAGE AT HOME: _____

(CHECK ONE)
☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT ☐ OTHER: _____

EMPLOYER_____EMPLOYER'S ADDRESS_____

PREFFERED PHARMACY _____

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY_____ID# _____Grp#_____

INSURED/CARD HOLDER'S NAME_____ RELATIONSHIP_____

DOB_____SOC.SEC#_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____ID#_____Grp#_____

INSURED/CARD HOLDER'S NAME_____ RELATIONSHIP_____

DOB_____SOC. SEC. #_____

EMERGENCY CONTACT

FIRST NAME_____MIDDLE_____LAST NAME_____

RELATIONSHIP_____SEX_____

HOME PHONE #(_____)_____WORK PHONE # (_____)_____CELL PHONE# (_____)_____

ACCIDENT

ACCIDENT ☐ YES ☐ NO **TYPE** ☐ AUTO ☐ WORK ☐ HOME ☐ OTHER

DATE & CIRCUMSTANCES OF INJURY_____

HOW/ WHERE DID THE INJURY OCCUR? _____

INSURANCE INFORMATION (PHONE NUMBER, POLICY NUMBER _____

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

FIRST NAME_____MIDDLE NAME_____LAST NAME_____

RELATIONSHIP_____DAYTIME PHONE# (___)_____ SOCIAL SECURITY #_____

ADDRESS_____ CITY_____STATE_____ZIP_____

EMPLOYER_____ADDRESS_____STATE_____ZIP_____

Tracey L. Brennan MD
324 West Ave.
Saratoga Springs NY, 12866
518-583-0000

Pediatric Health History Form

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____
CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER: _____
PRESENT HEALTH CONCERNS: _____
MEDICINES/VITAMINS: _____
HERBS/HOME REMEDIES: _____
ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Where was the child born? _____
Is this child yours by: ❑ birth ❑ adoption ❑ stepchild ❑ other: _____
Please indicate any medical problems during pregnancy ❑ none ❑ specify: _____
_____
Delivery by: ❑ vaginal birth ❑ caesarian If caesarian, why? _____
Birth weight: _____ Birth length: _____ APGAR score: 1 min. _____ 5 min. _____
Please indicate any medical problems during the baby's newborn period ❑ none If premature, how early?
_____
Other problems: _____

NUTRITION & FEEDING

Was your child breastfed? ❑ No ❑ Yes If so, how long? _____
Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify: _____
_____
Milk intake now: Type ❑ cow milk ❑ non-fat ❑ 1%fat ❑ 2%fat ❑ whole milk ❑ soy milk ❑ rice milk
Average ounces per day (Note: 8 ounces are in 1 cup) _____

SLEEP

Hours per night Naps (number & length) _____ Naps: _____
Any sleep problems? _____

DEVELOPMENT

At what age did your child: sit alone _____ walk alone _____ say words _____ toilet train (daytime)
Girls only: Age at first menstrual period _____

DENTAL HISTORY: Has child been seen by a dentist? ❑ No ❑ Yes If so, how often Date of last visit

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.
Has your child had: ❑ chickenpox ❑ measles ❑ mumps ❑ rubella ❑ meningitis ❑ tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure?(old home/plumbing/peeling paint)❑No ❑Yes
Do any household members smoke? ❑ No ❑ Yes
TV -hours per day _____ Computer-hours per day _____ Video Games-hours per day _____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates:
_____
_____
_____
Hospitalizations/Operations (with dates): _____

Broken bones or severe sprains: _____

FAMILY HISTORY: Please circle any family history of the following:

Alcoholism/drug abuse Heart disease or stroke before age 60 Seizures
Psychiatric disorders Thyroid disease Kidney disease High blood pressure
Bleeding/clotting problems Birth defects
Asthma/hay fever/eczema Inherited/genetic diseases

SOCIAL HISTORY:

Current (or upcoming) grade: _____

Who lives at home?

Name Age Relationship Highest Education Level

_____

_____

_____

_____

Are the child's parents ❑ married ❑ unmarried ❑ separated ❑ divorced If divorced, when?

Parents' occupations: Mother _____Father _____

Child care situation ❑ parents ❑ others (specify who and hours per day) _____

_____

Concerns about your child: ❑ Alcohol use ❑ Tobacco ❑ Sexual Activity ❑ Aggressive Behavior

Is violence at home a concern? ❑ No ❑ Yes Are there guns in the home? ❑ No ❑ Yes

SCHOOL HISTORY:

Did/does your child attend preschool? ❑ No ❑ Yes Current grade Name of school

Any concerns about school performance? _____

Any concerns about relationships with:

Teachers ❑ No ❑ Yes _____

Students ❑ No ❑ Yes _____

If over 4 years old does your child have a best friend? ❑ No ❑ Yes

Sports / exercise: Type _____ How often? _____ How long (minutes) _____