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Denver, CO 80249

Phone: (720) 734-8816
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NEW PATIENT REGISTRATION FORM

PATIENT INFO

Patient's Legal Name (Last, First, Middle) _____

Preferred Name / Nickname _____

DOB_____ Gender _____ Pronouns_____

Address _____
Street Address Apt#

_____
City Sate Zip Code

If child has their own phone number, please list here: _____

Hispanic/Latino Ethnicity (optional): _____ Yes _____ No

Race (optional): ____ White ____ Black/Afr.Am. ____ Asian ____ Native
____ Pacific Islander ____ Multiple/Other

INSURANCE SUBSCRIBER

Insurance Subscriber's Name _____ DOB _____

PARENT/GUARDIAN INFORMATION

Person #1 with legal decision-making power_____

Relationship to patient: _____ DOB _____ Gender _____

Same Address as patient? Yes_____ Other: _____

Best Phone Number: _____ Cell ____ Home ____ Work ____

Alternate Phone Number (optional): _____ Cell ____ Home ____ Work ____

Email: _____

Person #2 with legal decision-making power_____

Relationship to patient: _____ DOB _____ Gender _____

Same Address as patient? Yes_____ Other: _____

Best Phone Number: _____ Cell ____ Home ____ Work ____

Alternate Phone Number (optional): _____ Cell ____ Home ____ Work ____

Email: _____

Other Emergency Contact (optional)

Name _____ Relationship to Patient: _____

Phone Number _____ Cell ____ Home ____ Work ____

BIRTH & MEDICAL HISTORY

Was your child born on time? YES_____NO_____ If early, how early? _____weeks

Complications at birth? _____

_____

Does your child have any chronic medical problems (such as asthma or allergies)?

_____

_____

_____

Does your child have any chronic developmental problems (such as delays, autism, ADHD)?

_____

_____

_____

Has your child had any surgeries? _____

_____

_____

Does your child take medications?

Name of medicine How is it given? Dose

_____

_____

_____

Is your child allergic to anything?

Name of medicine/food Type of Reaction

_____

_____

_____

Medical Problems in the Family:

Child's mother _____

Child's father _____

Sibling _____

Sibling _____

Child's Grandmother (mother's side) _____

Child's Grandfather (mother's side) _____

Child's Grandmother (father's side) _____

Child's Grandfather (father's side) _____

If there is anything that you would like us to know about your child or your family, please describe below. Please share anything that will help me meet your child or family's needs, such as how you prefer to be addressed, if you or your child have fears or sensitivities around medical issues, or if there are any cultural norms we should respect.

_____

_____

_____

_____

_____

HOW TO RETURN THIS FORM:

1. **PREFERRED – Use the Spruce app – this will save you time at your first visit!**
    a. If already have the Spruce app, go into your conversation with Prairie Pediatrics and send the completed form as a photo or a PDF.
    b. If don't have the app, go to https://spruce.care/prairiepeds and click the blue "join" button to create an account. Start a new conversation with Prairie Pediatrics and send the completed form as a photo or a PDF.
2. Fax it to Prairie Pediatrics at 720-405-4454
3. Bring it with you at the time of your child's first appointment. Be sure to arrive 15 minutes before your scheduled appointment.