Jennifer Midgett, LLC / Premier Pediatrics of Louisiana
325 W. 8th St., Deridder, LA 70634
Tel: 337-221-3075 Fax: 337-221-3076
www.premierpediatricsla.net

Welcome to Jennifer Midgett LLC / Premier Pediatrics of Louisiana!

We are glad that you have chosen us to provide your primary care, and we are looking forward to working with you and/or your family. To complete the following information, you will need Insurance Cards, Driver's license, Social Security Numbers, Health Information, etc. all in relation to the patient.

PATIENT INFORMATION

First Name: Last Name: DOB: / /

Gender: Male ☐ Female ☐ Age: Social Security #: - -

Address:

City: State: Zip:

Home Phone: ( ) Cell Phone: ( )

Permission to leave message? Home: YES ☐ NO ☐ Cell: YES ☐ NO ☐ E-Mail: YES ☐ NO ☐

PREVIOUS PROVIDER INFORMATION

Doctor or Office: Location:

Office Phone: ( )

PHARMACY INFORMATION

Pharmacy Name:

Address: Phone #: ( )

PARENT/GUARDIAN INFORMATION

Parent/Guardian (First, M.I., Last): DOB: / /

Relationship to Patient: Social Security #: - -

E-Mail:

Home Phone: ( ) Cell Phone: ( )

Permission to leave message? Home: YES ☐ NO ☐ Cell: YES ☐ NO ☐ E-Mail: YES ☐ NO ☐

INSURANCE INFORMATION

Select all insurance types that apply. ☐ Private (Blue Cross, Cigna, ETC.) ☐ Medicaid ☐ Tricare/US Family/Champ VA

Primary Insurance: Policy Holder Name:

Policy Holder Sex: Male ☐ Female ☐ Policy Holder DOB: / /

Policy Holder SSN#: - - Relation to Patient:

ID #: Group #:

Secondary Insurance: Policy Holder Name:

Policy Holder Sex: Male ☐ Female ☐ Policy Holder DOB: / /

Policy Holder SSN#: - - Relation to Patient:

ID #: Group #:

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INITIAL HISTORY QUESTIONNAIRE

Patient Name (First, M.I., Last) : _____ DOB: _____/_____/_____

Form Completed By: _____ Date Completed: _____/_____/_____

HOUSEHOLD

# of BROTHERS:_____ **# of SISTERS:**_____ **# of Pets:**_____ ☐ Inside **# of Pets:**_____ ☐ Outside

What is the child's living situation if not with both biological parent?

☐ Joint custody ☐ Lives with adoptive parents ☐ Other
☐ Single custody ☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____
_____

BIRTH HISTORY

Don't know birth history ☐

Were there any problems in the pregnancy? *Please check all that apply.* ☐ Yes ☐ No ☐ Unknown

☐ Bleeding ☐ Diabetes ☐ High Blood Pressure ☐ Hospitalization ☐ Premature Labor ☐ Pre-eclampsia ☐ Surgery ☐ Toxemia
☐ Infection(s), please specify: _____ ☐ Other: _____

Were any medications or drugs used in the pregnancy? *Please check all that apply.* ☐ Yes ☐ No ☐ Unknown

☐ Prenatal vitamins ☐ Folic Acid ☐ Prescription medication ☐ Other drugs ☐ Alcohol ☐ Smoking
☐ If yes to any marked above, please specify: _____

Delivery

Mother's age at delivery: _____ Length of pregnancy: _____ weeks Labor: ☐ Spontaneous ☐ Induced, *reason*: _____
Delivery: ☐ Vaginal ☐ C-Section Were there any problems during delivery? ☐ No ☐ Yes, describe: _____
Birth weight: _____ Birth length: _____ Days spent in the hospital: _____

Were there any medical concerns when the child was a newborn? ☐ No ☐ Yes ☐ Unknown

☐ Breathing problems ☐ Jaundice ☐ Low muscle tone ☐ Feeding problems ☐ Birth defect *(specify)*: _____

Did your child spend time in the NICU? ☐ No ☐ Yes, explain: _____

GENERAL PATIENT MEDICAL INFORMATION

Does the patient have ANY serious illnesses or medical conditions? *(If yes, please list below)* ☐ Yes ☐ No ☐ Unknown
Explain: _____

Has the patient had ANY surgeries or hospital stays? *(If yes, please list below)* ☐ Yes ☐ No ☐ Unknown
Explain: _____

Is the patient allergic to ANY MEDICATION? *(If yes, please list below)* ☐ Yes ☐ No ☐ Unknown
Explain: _____

Is there any important family medical history that we should be aware of? *(If yes, please list below)* ☐ Yes ☐ No ☐ Unknown
Explain: _____

FAMILY MEDICAL INFORMATION

Does the patient have any Family Members with the following problems? *(If yes, please indicate relationship.)* ☐ Yes ☐ No ☐ Unknown
Explain: _____
_____
_____

Is there any other information that would be helpful for treating your child? ☐ Yes ☐ No ☐ Unknown
Explain: _____
_____
_____