CHRISTOPHER V. FLORES, MD
A MEDICAL CORPORATION

Name of Patient: _____ _____ _____ (First) (MI) (Last)	**Date of Birth:** _____ **Gender:** ☐ Male ☐ Female
Mother's Address: _____ _____	**Can we mail confidential information to mother's address?** ☐ Yes ☐ No
Father's Address: _____ _____	**Can we mail confidential information to father's address?** ☐ Yes ☐ No
Name of Mother: _____ **Mother's Tel**: Home: _____ Cell _____ **Name of Father:** _____ **Father's Tel**: Home: _____ Cell _____	**Child lives with:** ☐ Mother ☐ Father ☐ Both **Child attends:** School _____
Where can we leave a confidential message? *(Please check all that apply)* ☐ Mother ☐ Father **Emergency Contact:** Name: _____ Relationship: _____ Phone Number: Home: _____ Work: _____ Cell _____ Address: _____ _____	**PLEASE NOTE: We do not contract directly with any insurance (PPO, HMO, Healthy Families/Kids, Medicare or Medi-Cal). If you are on Medicare, we will be asking you to sign a Medicare Private Contract. Please note that Medicare, Medi-Cal, Healthy Families/Kids and HMOs will not allow you to seek reimbursement for our services.**

Insurance Information: Are you on Medicare Part B? ☐Yes ☐ No (We need insurance information to coordinate your care)

DR. FLORES HAS OPTED OUT OF MEDICARE & DOES NOT CONTRACT WITH ANY OTHER INSURANCE
IF YOU HAVE ANY QUESTIONS ABOUT WHAT THIS MEANS, PLEASE ASK DR. FLORES OR MARI

Primary Coverage: Insurance Company: _____ ☐ PPO ☐ HMO ☐ Other: _____ ID#:_____

Secondary Coverage: Insurance Company: _____ ID#:_____

Subscriber Information: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ **Subscriber's Date of Birth**: _____
Name and Address of Subscriber: _____

Your Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown ☐ Prefer Not to Answer
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic nor Latino ☐ Other ☐ Prefer Not to Answer

How did You Hear about Dr. Flores? _____

List of Doctors/Health Providers: _____
_____

CHRISTOPHER V. FLORES, MD
A MEDICAL CORPORATION

List of Illness/Hospitalizations/Surgeries (include Dates and Names of Hospital/Clinic/Facility): _____
_____
_____
_____

Allergies to any Medications? □ Yes □ No
Please list and describe reaction: _____
_____
_____
_____

Allergies to any Foods? □ Yes □ No
Please list and describe reaction: _____
_____
_____
_____

List of Prescription, Vitamins and Herbal Medications Currently Taking:
_____
_____

Family History: Any history in any blood relative of the following:

Allergies □ Yes □ No	Heart Trouble □ Yes □ No	Lung Disease □ Yes □ No
Cancer □ Yes □ No	Diabetes □ Yes □ No	Tuberculosis □ Yes □ No

Concerns (Please check all that apply)

- □ Eats too little (Diet/Weight)
- □ Eats too much (Diet/Weight)
- □ Cries a lot
- □ Behavior problems
- □ Always has runny nose, cough or allergies
- □ Frequently constipated
- □ Seems small for age
- □ School problems/poor school performance
- □ Speaks unclearly
- □ Wets bed
- □ Problems sleeping
- □ Sees poorly
- □ Doesn't always respond to noise or spoken word
- □ Has frequent temper tantrums
- □ Cramps/Irregular period (female)
- □ Anger/Attitude
- □ Smoking/Drugs
- □ Mood/Depression
- □ Skin/Acne

Other: _____

****VACCINATION HISTORY****

Hepatitis B □Yes □No
When? _____

DTaP/Tdap □Yes □No
When? _____

Haemophilus Influenza type B (HiB)
□Yes □No When? _____

Polio □Yes □No
When? _____

Pneumococcal (PCV) □Yes □No
When? _____

Rotavirus □Yes □No
When? _____

Measles, Mumps, Rubella (MMR)
□Yes □No When? _____

Varicella □Yes □No
When? _____

Hepatities A (Hep A) □Yes □No
When? _____

Human Papillomavirus (HPV)
□Yes □No When? _____

Meningococcal (MCV4)
□Yes □No When? _____

Influenza
□Yes □No When? _____

THE FOLLOWING IS ONLY FOR CHILDREN 5 YEARS OR YOUNGER
PLEASE DO NOT FORGET TO SIGN FIRST VISIT FORM ON PAGE 3

Your Child's Birth History: How early, *after* you became pregnant did you start seeing a doctor? _____ months

During your pregnancy with this child, did you:

Have high blood pressure?	□Yes□No	Get treatment for gonorrhea or syphilis?	□Yes□No
Have diabetes?	□Yes□No	Drink alcohol?	□Yes□No
Have protein in the urine?	□Yes□No	Have this child early (premature)?	□Yes□No
Have a urinary infection?	□Yes□No	Have more than one baby delivered?	□Yes□No
Have German (3 day) measles?	□Yes□No	Have a difficult labor/delivery?	□Yes□No
Take any medicines?	□Yes□No	Was it a breech (bottom first) delivery?	□Yes□No

Smoke cigarettes?	☐Yes☐No	Was it a caesarean delivery?	☐Yes☐No

THE FOLLOWING IS ONLY FOR CHILDREN 5 YEARS OR YOUNGER
PLEASE DO NOT FORGET TO SIGN AT THE BOTTOM OF THIS PAGE

Your Child's Social/Development History

Did the baby breath/cry immediately at birth?
☐Yes☐No

Was the baby jaundice at birth? ☐Yes☐No

Did the baby have an RH problem? ☐Yes☐No

Receive blood? ☐Yes☐No

At birth, did the baby appear normal? ☐Yes☐No

Was Sickle Cell Testing done at birth? ☐Yes☐No

Was PKU Testing done at birth? ☐Yes☐No

During the baby's FIRST year, did you breast feed?
☐Yes☐No

How long did you breast feed?
_____

During the baby's first year, did you formula feed? ☐Yes☐No

If you had feeding problems, please explain:
_____

How old was the baby when he/she was completely weaned from the breast?_____

How old was the baby when you started giving the baby whole milk?
_____

Any problems or allergies?
_____
_____

How old was the baby when you started giving the baby solid food?
_____

Any problems or allergies?
_____
_____

By signing below, I acknowledge that the information provided is true and correct to the best of my knowledge.

Your Name: _____ Date: _____
(Parent, Guardian or Caretaker)

Your Signature: _____
(Parent, Guardian or Caretaker)