MANNAN PEDIATRICS
NEW PATIENT INFORMATION FORM
Please complete the entire form

📌 Patient Information

Full Name: _____
Date of Birth: _____ **Gender:** ☐ Male ☐ Female
Race: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Previous Doctor: _____
How did you hear about us?: _____
Insurance Provider: _____ **Member ID:** _____
Preferred Pharmacy:_____

👫 Parent/Guardian Information

Mother's Name: _____
Phone: _____ **Email:** _____
Occupation: _____ **Age:** _____
Father's Name: _____
Phone: _____ **Email:** _____
Occupation: _____ **Age:** _____
Child lives with: ☐ Mother ☐ Father
Is the child adopted? ☐ Yes ☐ No **In foster care?** ☐ Yes ☐ No
Foster Parents Name: _____ **Phone:** _____
Siblings (Names & Birthdates): _____

🍼 Birth & Delivery Details: Mother's age at child's birth: _____

Type of Delivery: ☐ Vaginal ☐ C-Section **Feeding:** ☐ Breast Milk or ☐ Formula
Birth Weight: _____ lbs. **Gestational Age:** _____ weeks carried
Birth Hospital: _____
Pregnancy/Delivery Complications (check all that apply):
☐ Infection ☐ Diabetes ☐ Drug/Alcohol Use ☐ Cigarette Use ☐ Early Labor ☐

🩺 Medical History: Current Medications: _____

Chronic Conditions: ☐ Yes ☐ No– Explain: _____
Hospitalizations: ☐ Yes ☐ No– Explain: _____
Surgeries: ☐ Yes ☐ No– Explain: _____
Emergency Room Visits: ☐ Yes ☐ No– Explain: _____
Food Allergies: ☐ Yes ☐ No– Explain: _____
Medication Allergies: ☐ Yes ☐ No– Explain: _____
Immunization Reactions: ☐ Yes ☐ No– Explain: _____

🧠 Past Illnesses (Check all that apply)

☐ Chickenpox ☐ Seizures ☐ RSV ☐ Ear infections (>5/year)
☐ Anemia ☐ Eating Disorder ☐ UTI ☐ Loud Snoring ☐ Reflux
☐ Headaches ☐ Pneumonia ☐ Poor School Performance
☐ Heart Murmur ☐ Depression/Emotional Issues
Explain any checked items: _____

🧬 Family Medical History (Check and list relative)

☐ ADD/ADHD ☐ Allergies ☐ Asthma ☐ Arthritis ☐ Autism
☐ Cancer ☐ Diabetes (under age 25) ☐ Developmental Delays
☐ Heart Disease (under age 50) ☐ Mental Illness ☐ Stroke (under age 50)
☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease
☐ Liver Disease ☐ Migraines ☐ Epilepsy/Seizures
☐ Scoliosis ☐ Immune Disorders ☐ Rare Diseases
☐ Obesity ☐ TB ☐ Thyroid Disorders
☐ Sudden Cardiac Death ☐ Infant Death/SIDS
☐ Eye Problems ☐ Ear Problems ☐ GI Disorders
☐ Learning Disabilities ☐ Eczema ☐ Other: _____

🔎 Behavioral

Any developmental/behavioral concerns? ☐ Yes ☐ No
Consent for Emergency Contacts & Vaccine Policy
Emergency Contacts:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Consent for Text/Telehealth Visits: ☐ Yes ☐ No

To protect patient confidentiality and maintain a respectful clinical environment, the use of video recording, audio recording, or photography during appointments is strictly prohibited.

At Mannan Pediatrics we follow AAP guidelines and do NOT accept patients who opt out of vaccines. Please sign below

Parent/Guardian Signature: _____ Date: _____