Dear Parent,

Thank you for putting your trust in Allegan Professional Health Services to meet your healthcare needs. You have requested an appointment at: Gobles Medical Clinic, Otsego Medical Center, Fennville Medical Center, or Allegan Medical Clinic. As a parent you can help ensure that your child's first visit runs smoothly.

As soon as you receive this new patient packet, please complete and return all forms to our office so that we can request your child's records from their previous provider(s). (The patient handbook is yours to keep.) When we receive your child's information, we will contact you to schedule a new patient appointment. They will be scheduled for the first available appointment that works for your schedule. Often this can be four or more weeks out on our schedule. If you no show for your child's new patient appointment, your child may be denied as a new patient to this facility. If you need to cancel this new patient appointment for any reason, you must do so 24 hours prior to the appointment time or it will be considered a no show appointment.

It is essential that you review the patient handbook enclosed in this packet. The handbook contains our hours of operation, medication refill policy and procedures, patient rights & responsibilities, patient portal information, our late policy, as well as other resources available to our patients.

We look forward to meeting your family's needs and serving you now and in the future. If you have any questions, please contact our office at Gobles Medical Clinic (269) 628-2196, Otsego Medical Center (269) 694-9640, Fennville Medical Center (269) 561-8761, and Allegan Medical Clinic (269) 686-5800.

Thank you,

Allegan Professional Health Services Providers & Staff

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To maintain the accuracy of your records we may ask that you fill this form out once a year.

Parents: Please complete this form with your child's information.

Name: ____ Date of Birth: __________________________

Preferred Pharmacy: _______________________________ Primary Language: ______________________

Race: Asian American Indian or Alaska Native African American Native Hawaiian
Other Pacific Islander White More than One Race Do Not Wish to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Do Not Wish to Report

Medical Allergies: ____ None

Birth History: Fill out as much as you can. It is OK if you do not know an answer, just skip to next question.

Prenatal

Did you receive prenatal care? YES NO
Any maternal illness/complications/infections during pregnancy? NO YES ____________________________
Gestational age at birth _________ weeks

Delivery

Type of delivery: Vaginal (Natural) Vaginal (Vacuum or Forceps) Planned C/S Unplanned C/S
Reason for unplanned C/S____

Birth weight:_________ pounds _________ ounces
Any complications with delivery? NO YES ____
How many days did your child spend in the hospital? _________ days

Nutrition

Food Type	Servings/Day
Fruits	
Vegetables	
Bread/Cereals	
Proteins	
Dairy/Calcium Containing	
Juice	

Type of Diet:___________________________________ Supplements Given:___________________________
Excess junk food/snacks: Candy Chips Cookies Fast Food Fried Food Ice Cream Snacks
Excess soda/juice: Caffeinated Diet Caffeinated Regular Decaf Diet Decaf Regular

Dental

Last Visit Date: ___________________ No Concerns Cavities Erosion Disease Uses Pacifier

Elimination

Bladder: No Concerns______ Concerns:____
Bowel: No Concerns______ Concerns:____

Sleep

Sleeps with parents? NO YES Sleeps through night? YES NO >8 hours of sleep/night YES NO
Nightmares/Problems NO YES Explain:____

Education

School Name____ Grade_______ Grades Earned___________
Special needs? YES NO Learning disabilities? YES NO Gifted Program? YES NO
Likes school? YES NO Truancy? YES NO Cooperates at school? YES NO
Ever been suspended/expelled? NO YES, why?____
Repeated any grades? NO YES, what grade?____
Performing: Below grade level At grade level Above grade level

Activity

Hours of TV/computer games per day _______ TV in room? YES NO
Computer in room? YES NO Has chores? YES NO

Exercise/Sports/Activity

Hours per week: _______ Type:____

Family & Relationships

Parents are: Married Divorced Separated Live Together Never Together Friends
Father in Jail Mother in Jail
Child resides with: Mother ________% of the time Father________% of the time
Occupations: Mother __________________________ Father________________________________
# of Siblings: _________ Brothers _________Sisters Birth Order______________________
Cooperates with family/friends? YES NO Has friends? YES NO Friends of both sexes? YES NO
Is your child cared for by someone else while you work? Center Daycare Homecare Babysitter Relative

Home Environment & Safety

Home Type: House Apartment Shelter Single Family Multi Family
Age of Home: <10 years 10-25 years >25 years
Is home safe? NO YES Heat type:___________________________________
Water source: City Well Bottled Chlorinated? YES NO Fluoridated? YES NO
Lead in home? NO YES
Car Restraints: Seatbelt ______ Booster ______ NONE ______
Uses bike helmet? YES NO
Known TB exposure? NO YES
Smoker in home? NO YES If someone smokes, do they smoke outside only? YES NO
Smoke detectors in home? YES NO Carbon monoxide detectors in home? YES NO
Radon in home? NO YES NEVER TESTED
Firearms in home? NO YES If yes, # in home______ Are they locked up? YES NO
Is ammunition stored separately? YES NO
Used for: Recreation Hunting Occupation Protection
Do you have a pool or spa at home? NO YES
Animals in the home? NO YES Type:____

Surgical History

Has your child ever had surgery? If yes, please explain:

Surgery Type	Date

Medical History

Does your child have any medical problems? Please list:____
____

Has your child ever been seen by a specialist? Please list: ____
____

Family History:

	Who *(Mother, father, sister, brother, grandparent)*	**Age@ onset or death**	**Check if cause of death**		**Who** *(Mother, father, sister, brother, grandparent)*	**Age@ onset or death**	**Check if cause of death**
ADD/ADHD				Hearing Deficiency			
Alcoholism				High Cholesterol			
Allergies				Hypertension			
Alzheimer's Disease				Irritable Bowel Disease			
Asthma				Learning Disability			
Blood Disease				Mental Illness			
CAD				Migraines			
CAD Premature				Obesity			
Cancer				Osteoarthritis			
Type:				Osteoporosis			
CVA (Stroke)				PVD			
Depression				Renal Disease			
Developmental Delay				Seizure			
Diabetes				Other			
Eczema				Other			

Current Medications:

Medication Name	Dose	Frequency	Original Prescriber

Additional Comments:

Here at Allegan Professional Health Services, we have created a new patient process that assures we will have all the information necessary to better assist your child with his/her healthcare needs. This new patient appointment is scheduled so that you can establish care for your child with one of our providers. Please understand that this appointment is not the appropriate time to expect treatment for current issues. The provider will utilize this time to get to know you and your child and his/her healthcare needs and concerns. This appointment will allow time to collect the information needed to assure a positive relationship in this practice. If your child is having an issue please call our reception staff to schedule an acute care appointment. We look forward to caring for your family.

Thank you,
Allegan Professional Health Services Staff