

Washington International Pediatrics



Welcome!

New Patient Registration Form

Patient(s) Information

Child #1: _____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:** _____

Child #2: _____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:** _____

Child #3: _____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:** _____

Child #4: _____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:** _____

Child #5: _____ ☐ Male ☐ Female ☐ Other/Non-Binary, **DOB:** _____

Home Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Child(s) country of birth: _____

*****Please send us a copy of the immunization record and insurance card front/back*****

Parent#1

Name: _____ ☐ Male ☐ Female ☐ Other/Non-Binary, DOB: _____

Address (if different from patient's):

Home Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ E-mail: _____

Profession: _____

Parent#2

Name: _____ ☐ Male ☐ Female ☐ Other/Non-Binary, DOB: _____

Address (if different from patient's):

Home Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ E-mail: _____

Profession: _____

*****Incomplete form will result in a delay to complete registration, and scheduling appointments with the doctors *****



No Show & Late Cancellation Policy

A great deal of planning is done for your child's appointment. Changes and cancellations to our schedule without proper notice are very disruptive to our patient care. For this reason, we ask that changes to your appointment be made at least 24 hours in advance. A \$75 fee will be assessed for late cancellations and no shows.

Late arrival: We will do our best to accommodate patients arriving past their scheduled appointment time for well visits. If running more than 15 minutes late, the appointment may need to be rescheduled to prevent delays in seeing other scheduled patients. Please notify us as soon as possible if you are running late.

Signature

Date

School Forms, Health Forms & Other Medical Forms

We charge a \$30 administrative fee for forms and letter requests, per child. Additional form requests made at a later time will be subject to a separate \$30 fee. Expedited forms requiring a same-day turnaround will be charged a \$50 fee.

Signature

Date



After-Hours Calls & Texts Messages to Providers

In case you seek medical advice outside our regular office hours you will be subject to an after hour call fee of \$50. This is effective as of July 1, 2025. This fee applies to text messages seeking medical advice as well. This does not include emails and portal messages sent to providers outside of office hours.

Signature

Date

COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Birthday: _____

Parent #1: Name _____ Phone number: _____

Parent #2: Name _____ Phone number: _____

Please list all of your child's medical conditions.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

What surgical or medical procedures has your child had in the past?

If parents are not living together, what is the custody arrangement?

Please list everyone who lives in the home (include immediate family, step or half siblings)

Name	DOB
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

What medications, herbs, and vitamins/supplements are you currently taking?
Remember to include over-the-counter medicines. Please include the doses and how often you take each one.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Allergies? YES ___ NO ___

If "yes", reactions? _____

Do you have any pets? YES ___ NO ___, TYPE: _____

Type of Water? City ___ Well ___

Do you have any gun(s) in the home? YES___ NO___

Does anyone smoke (inside or outside)? Including vapes? YES___ NO___
Marijuana use YES___NO___

Do you have working smoke and carbon monoxide detectors in the home?
YES___NO___

Please tell us about medical conditions in your family history, if yes please state whom:

<u>Health history</u>	<u>YES</u>	<u>NO</u>
Stroke before age 55 yrs		
High Blood Pressure/hypertension		
Diabetes		
Arthritis		
Seizures		
Depression		
Mental illness (anxiety/depression)		
Asthma		
Heart attack		
Elevated cholesterol		
Thyroid disease		
Kidney Disease		
Gastrointestinal disease (ulcer,GER, IBD)		
Bed wetting/enuresis		
Developmental delays/autism		
Cancer		
Allergies		
Hearing Loss		
Other		