Vinaya K. Gavini M.D.F.A.A.P., Infants, Children & Adolescents, 26850 Providence Parkway Suite 300, Novi, MI 48374

LAST NAME	FIRST NAME	D.O.B.

NEW PATIENT QUESTIONNAIRE

Instructions: Please fill out as completely as possible. All information will be kept confidential.

HEALTH CARE STATUS

Where has your child gone for check-ups until now? _____		
What is the date of your child's last check-up? _____		
What is the date of your child's last dental check-up? _____		
Is your child under treatment for any illness/condition? What? _____ With whom? _____	**N**	Y
Has your child had any allergic reactions to medications, food, or bee stings? Please List _____	**N**	Y
Has your child had reactions to any immunizations? Please list _____	**N**	Y
Has your child had any hospitalizations other than birth? Please list _____	**N**	Y
Does your child take any medications, including over-the-counter medication such as Tylenol or vitamins? Please list _____	**N**	Y

REVIEW OF SYSTEMS

Has your child had frequent ear infections?	**N**	Y
Has your child had any eye/vision problems?	**N**	Y
Has your child had any problems with teeth?	**N**	Y
Does your child have frequent colds or sore throats?	**N**	Y
Is there asthma, pneumonia, or a recurrent cough?	**N**	Y
Does your child have problems with urination?	**N**	Y
Any eczema, hives, or other skin conditions?	**N**	Y
Have there been any convulsions or other problems with the nervous system?	**N**	Y
Does your child have a heart murmur or any heart problems?	**N**	Y
Any problems with diarrhea or constipation?	**N**	Y
Has your child ever been anemic?	**N**	Y
Please list any other medical problems: _____ _____		

PREGNANCY AND BIRTH

Mother's age at birth of this child _____		
Did mother have any illnesses during this pregnancy?	**N**	Y
Did mother use any medications other than vitamins?	**N**	Y
Was the baby born on time?	**Y**	N
What was the baby's birth weight? _____		
Did the baby have any trouble starting to breathe?	**N**	Y
Did the baby have any trouble (jaundice, infections, etc.)? What kind? _____	**N**	Y

DEVELOPMENT/BEHAVIOR

At what age did your child sit alone? _____		
At what age did your child walk alone? _____		
Did he/she speak any words by age 1½?	**Y**	N
Does your child have trouble sleeping?	**N**	Y
What grade is your child in? _____		
Has your child had any trouble in school?	**N**	Y
Does your child get along well with other children?	**Y**	N
Can your child keep up with other children?	**Y**	N

FAMILY HISTORY

Please list any blood relatives who have had the following illnesses.

Illness	**Relative**
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Blood Disease	
Epilepsy	
Asthma/Allergies	
Tuberculosis	
Other	

FEEDING AND NUTRITION

Is your child's appetite usually good?	**Y**	N
Is it good now?	**Y**	N
Was there severe colic or any unusual feeding problems in the first 3 months of life?	**N**	Y
Do any foods disagree with your child?	**N**	Y
Is/Was your child (Please circle) *breast fed* or *bottle fed* or *both* ?		
If the child is still on formula, which one do you use? _____		
Does your child take vitamins?	**Y**	N

Please list the general health, age, and sex of parents, brothers, and sisters.

Name	General Health	Age	Sex
Have any of your children died?		**N**	Y

SAFETY/ENVIRONMENT

We live in a private house, apartment, mobile home, other. (circle)		
Do you keep the hot water heater <120 F?	**Y**	N
Is there a working smoke alarm on each floor at home?	**Y**	N
Does your child always use a seat belt/car seat when in a car?	**Y**	N
Does your child wear a helmet when riding a bike?	**Y**	N
Are there any smokers in the house?	**N**	Y
Are there any firearms in the home?	**N**	Y
Have any of the child's caregivers been trained in CPR?	**Y**	N
Do you have the number for POISON CONTROL?	**Y**	N
Do you have syrup of IPECAC in your home?	**Y**	N

*If you have a copy of the child's immunization please include it with this form.

Name of person completing the form: _____

Relationship: _____ Date: _____ Physician Signature: _____

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FAMILY AND INSURANCE INFORMATION

Party Responsible for Payment

Patient's Name	Date of Birth	Age	Social Security #	Male / Female

Father's Name	Date of Birth	Social Security Number	Married / Single

Address	City	Zip Code	Phone

E-mail Address	Cell Phone

Mother's Name	Date of Birth	Social Security Number	Married / Single

Address	City	Zip Code	Phone

E-mail Address	Cell Phone

Father's Employer	Address	Phone

Mother's Employer	Address	Phone

Primary Insurance

Name of Insurance Company	HMO / PPO

Policy Holder's Name	Effective Date	Contract Number

Group Number	Coverage Code	Policy Number

Name of Group	Insurance Phone	Mail Claims to (complete address):

Secondary Insurance

Name of Insurance Company	HMO / PPO

Policy Holder's Name	Effective Date	Contract Number

Group Number	Coverage Code	Policy Number

Name of Group	Insurance Phone	Mail Claims to (complete address):

Emergency Contact	Phone	Relationship

Who referred you to our office?

Assignment of Benefits: I authorize the payment of Medical benefits to Vinaya K. Gavini, M.D. for the professional services rendered to my children. I understand that I am financially responsible for all the charges for services rendered to my child by Vinaya K. Gavini, M.D. including the balance remaining after the payment of possible insurance benefits.

"No-show" policy: If you fail to cancel and fail to show up for the appointment, we may charge your account $20 "no-show" charge. I am aware of this policy and agree to pay such charges.

_____ _____

Signature of Parent or Guardian **Date**