

TO MEET INTERVIEW FORM
(PLEASE COMPLETE AND BRING WITH YOU FOR YOUR INTERVIEW)

This information will be kept in our files for office use only. If you choose our doctors as your primary care physicians, this information will become part of your child's permanent record in our office.

MD you are seeing today _____ Todays Date _____

Name of Insurance carrier? _____

Parent/Guardian: Last name *(please print)* _____ First Name _____ Relationship to child _____

Parent/Guardian: Last name *(please print)* _____ First Name _____ Relationship to child _____

ADDRESS _____

May we call you to follow up after today's visit? Yes No Phone #: _____

FAMILY HISTORY

Parent	Birth Date	Ht.	Wt.	Medical Problems	Education Level

Any history in your child's relatives (grandparent, sibling, aunt, uncle) of: *(please check appropriate items)*

- ___ Interrupted Pregnancies ___ HIV/AIDS ___ Birth Defects ___ Kidney Disease
- ___ Tuberculosis ___ Diabetes ___ Chemotherapy ___ Thyroid Disease
- ___ Allergies ___ High Cholesterol ___ Bleeding Tendencies ___ Liver Disease
- ___ Convulsions/Epilepsy ___ High Blood Pressure ___ Other Heart Disease ___ Early Heart Attacks
- ___ Substance Abuse ___ Mental/Emotional Problems
- ___ Sudden/Unexpected death or fatality from illness ___ Other

Reason for changing provider? _____

Children? *(Please list name, age and gender)* _____

Doctor Notes: _____

Whom may we thank for referring you to our practice? _____

Do we have permission to use your name in our thank you correspondence? Yes No

Physician's Signature