

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

To meet _____