Pediatric Intake

Patient Name:_______________________________**DOB:**________________**Date:**________________________

Mother Name:_______________________________ Father Name:____________________________________

Legal Guardian Name: ____________________________________ Relationship: ________________________

Birth Weight:_______________________________ Birth Length (height):______________________________

Gestational Weeks at Delivery:_____________

Delivery Type (vaginal, C-section, VBAC, etc.):____

Newborn Jaundice: ☐ No ☐ Yes, treatment type/duration: ________________________________

Immunizations: ☐ Current ☐ Off schedule ☐ None

If immunizations have been done elsewhere, records must be provided that we can copy and keep on file at this office.