Vinson K. Diep, M.D., Inc.
Pediatrics

PATIENT REGISTRATION FORM

CHILD'S NAME:

_____ **BIRTHDATE:** _____ **SEX:** ☐ **Male** ☐ **Female**
Last First Middle

SEQUENCE OF CHILD IN THE FAMILY: ☐ **1st** ☐ **2nd** ☐ **3rd** ☐ **4th** ☐ **5th**

OTHER CHILDREN:

Name(s):	Birthdate(s):	Sex:
_____	_____	☐ M ☐ F
_____	_____	☐ M ☐ F
_____	_____	☐ M ☐ F
_____	_____	☐ M ☐ F

ADDRESS: _____
Street City State Zip Code

PARENTS: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

FATHER'S NAME: _____ **BIRTHDATE:** _____
EMPLOYER: _____ **MOBILE #:** _____
OCCUPATION: _____ **EMAIL:** _____
ETHNICITY: _____

MOTHER'S NAME: _____ **BIRTHDATE:** _____
EMPLOYER: _____ **MOBILE #:** _____
OCCUPATION: _____ **EMAIL:** _____
ETHNICITY: _____

EMERGENCY CONTACT (not parents)**:** _____
PHONE #: _____ **RELATIONSHIP:** _____

WHO IS RESPONSIBLE FOR THE CHILD(REN)'S BILL? ☐ **Father** ☐ **Mother**
ADDRESS: ☐ **Same as above** _____
Street City State Zip Code

HOW DID YOU HEAR ABOUT US?
- ☐ **Doctor** _____
- ☐ **Family** _____
- ☐ **Friend** _____
- ☐ **Website/Yelp/Google**
- ☐ **Insurance Company**
- ☐ **Other** _____

SOCIAL HISTORY
Primary language(s) spoken at home
_____
Who lives at home?
_____
Does anyone smoke? ☐ **No** ☐ **Yes** **Who?**
_____
Any pets at home? ☐ **No** ☐ **Yes**
_____

Phone: (808) 945-9955
Fax: (808) 945-9988
Email: pediatrics@doctordiep.com

Kapiolani Medical Center for Women & Children
1319 Punahou St Suite 1190
Honolulu, Hawaii 96826

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MEDICAL/FAMILY HISTORY QUESTIONNAIRE

Has your child ever been hospitalized after birth? ☐ Yes ☐ No
Please describe: _____
Has your child ever had any surgeries? ☐ Yes ☐ No
Please describe: _____
Any allergies (pets, foods, medications, etc)? ☐ Yes ☐ No
Please list them and their reactions: _____
Name of dentist: _____
Last dental visit: _____
Does your child see a specialist (ENT, ophthalmologist, psychiatrist, etc)?
☐ Yes _____ ☐ No

Has your child ever had the following:	Has anyone in the family ever had the following:	Who?
☐ None	☐ None	
☐ Anemia/bleeding	☐ Anemia/bleeding	_____
☐ ADHD	☐ ADHD	_____
☐ Asthma	☐ Asthma	_____
☐ Cancer	☐ Cancer	_____
☐ Blood transfusions	☐ Blood transfusions	_____
☐ Developmental problems	☐ Developmental problems	_____
☐ Diabetes	☐ Diabetes	_____
☐ Ear/nose/throat problems	☐ Ear/nose/throat problems	_____
☐ Eczema	☐ Eczema	_____
☐ Eye problems	☐ Eye problems	_____
☐ Heart defect/murmur	☐ Heart defect/murmur	_____
☐ High blood pressure	☐ High blood pressure	_____
☐ High cholesterol	☐ High cholesterol	_____
☐ Kidney problems	☐ Kidney problems	_____
☐ Liver problems	☐ Liver problems	_____
☐ Psychiatric problems	☐ Psychiatric problems	_____
☐ Seizures	☐ Seizures	_____
☐ Thyroid problems	☐ Thyroid problems	_____
☐ Other: _____	☐ Other: _____	_____

I understand and agree that regardless of my insurance status, I am responsible for any balance of my account for professional services rendered. I have read the "Office Payment Policy" & I have completed the above information to the best of my knowledge. I will notify Dr. Diep or his office staff of any changes in my child(ren)'s health status or in any above information. My signature below authorizes the release of any information to any of my child(ren)'s insurance companies which is necessary to process insurance claims. I WILL ALSO PAY $45.00 CHARGE FOR ANY RETURNED CHECK(S). PLEASE CALL 48 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE APPOINTMENTS

SIGNATURE: _____ **DATE:** _____

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