Pediatric Associates of Conn., P.C.

160 Robbins St
Waterbury, CT 06708

1 Pomperaug Office Park
Southbury, CT 06488

(203) 755-2999

*** WE DO NOT ACCEPT DISCS/USB ***

Pre- registration Intake Form

Date: _____

Patient's Name: _____ D.O.B: _____ Sex: (circle one) **M / F**

Parent Name: _____ Address: _____

Phone #: _____ E-mail : _____

Marital Status: (Circle One) Married Single Separated IF DIVORCED: Joint Custody Sole Custody

Insurance Company: _____ ID #: _____

Card Holder Name: _____ Card Holder D.O.B: _____

**Verification of PAC EMR: (For office use only) Date: _____ By: _____**

1. Have you ever been a patient of Pediatric Associates or seen any of our Physicians, if so who/when?

2. Previous pediatrician's name, address, and phone number?

3. It is the policy of Pediatric Associates of Conn., PC in accordance with the American Academy of Pediatrics that we are a "pro-vaccine" practice.
   Is your child up to date with their immunizations _____.
   Has your child been fully vaccinated _____?

4. Does your child do annual well visits: **YES/NO** If **NO** reason:

Pediatric Associates of Conn., P.C.

5. Does your child have any known allergies?

6. Does your child have any medical concerns?

7. Does your child take any medications?

8. Is your child under the care of any specialists, therapists, counselors etc.? If so, please EXPLAIN.

9. Has your child ever been treated for any serious medical conditions?

10. Has your child ever been treated for any psychiatric conditions?

11. Is there any history of Psychiatric Condition or Counseling? **Yes** **No**

12. Has your child ever been hospitalized for any reason or had any surgeries?

13. Do you need an apt: _____ How will you obtain Medical Release :

Print Mail Pick – Up

Approved by: _____

Registered by: _____