El Paso Pediatric Associates, P.A.

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PATIENT RECORD

Name _____ Birth Date _____ Male/Female _____ Blood type _____
Father's Name _____ S.S.# _____ Phone( ) _____
Mother'sName _____ S.S.# _____ Phone( ) _____
Father's Address _____ City _____ State _____ Zip _____
Mother'sAddress _____ City _____ State _____ Zip _____
Child's S.S.# _____ Referred by: _____
Father's Employer _____ Phone( ) _____
Mother's Empoyer _____ Phone( ) _____
Insurance Carrier _____ Ins. ID# _____

FAMILY HISTORY

AGE HEALTH ALLERGIES OR OTHER PROBLEMS
Mother _____
Father _____
Children _____

PAST HISTORY

PCP _____ Hosp. _____ Gestation _____ Birth Wt. _____ Length _____
Condition/Complications at Birth _____
_____
Hospitalizations _____
_____
Drug Allergies _____
_____
Reactions to Immunizations _____
Any Additional Concerns _____

PLEASE DO NOT FILL BELOW **OFFICE USE ONLY**

IMMUNIZATIONS

VACCINE	VIS DATE	1ST	2ND	3RD	4TH	BOOSTER	BOOSTER	
HEP-B	(07-18-07)							
DTAP	(05-17-07)							
IPV	(01-01-00)							
HIB	(12-16-98)							
PCV7	(09-30-02)							
ROTAVIRUS	(04-12-06)							
MMR	(01-15-03)							
VARIVAX	(01-10-07)							
HEP -A	(03-21-06)							
TDAP	(07-12-06)							
MCV4	(01-28-08)							
HPV	(02-02-07)							
PPD								
FLU	(current yr)							