

**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