DAVID B. MUNRO M.D., P.C.

JOSHUA D. MUNRO M.D.

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Telephone: (517) 787-7805 FAX: (517) 787-1611

PATIENT INFORMATION
CHILD HISTORY

Please Print

TODAY'S DATE

CHILD'S NAME (LAST) FIRST MIDDLE	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY #
ADDRESS (STREET)		CITY	STATE / ZIP
TIME SINCE LAST PHYSICAL EXAM	LAST SCHOOL GRADE COMPLETED	AVERAGE SCHOOL GRADES	HOBBIES & INTERESTS
LEGAL GUARDIAN	EMERGENCY CONTACT PERSON	TELEPHONE #	
HOME PHONE	WORK #	CELL #	E-MAIL
OCCUPATION	EMPLOYER	IF NOT EMPLOYED, INDICATE SOURCE INCOME	
MICHIGAN DRIVER'S LICENSE	HOW DID YOU HEAR ABOUT US?		

HEALTH OF FAMILY

FAMILY MEMBER	GOOD	POOR	DIED	IF DIED, NOTE AGE AND CAUSE (INCLUDES FATAL ACCIDENTS AND SUICIDES)
FATHER (Natural, biological)				
MOTHER (Natural, biological)				
BROTHERS & SISTERS:				
SPOUSE				
CHILDREN				

ILLNESS

IF YOU HAVE HAD ANY OF THE FOLLOWING, CHECK THE APPROPRIATE BOX.

☐ MUMPS, MEASLES, CHICKEN POX ☐ RUBELLA, GERMAN MEASLES ☐ RHEUMATIC FEVER

HOSPITALIZATIONS / SURGERY

LIST ILLNESS OR OPERATION, AND APPROXIMATE YEAR.

Year	Year
Year	Year
Year	Year

MEDICINE ALLERGIES

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

MEDICINES

LIST ALL MEDICINES, BIRTH CONTROL PILLS, OR VITAMINS YOU TAKE WITH OR WITHOUT A PRESCRIPTION:

	DATE	AGE GIVEN	DIPTHRERIA	WHOOPING COUGH	TETANUS							COMMENTS
DATE												
MATERIAL												
RESULT												
PHYSICIAN												
DATE												
MATERIAL												
RESULT												
PHYSICIAN												
DATE												
MATERIAL												
RESULT												
PHYSICIAN												
DATE												
MATERIAL												
RESULT												

I acknowledge that I have been offered the opportunity to read David B. Munro, M.D., P.C.'s Notice of Privacy and acknowledge the availability of a personal copy if I desire. Patient Financial Responsibility: I will provide all insurance cards . I authorize the release information needed to process any insurance claims. After 60 days, all charges, not paid by my insurance(s), are my responsibility. All co-pays and outstanding balances are to be paid before I see Dr. David B. Munro or Dr. Joshua D. Munro.

I hereby authorize the release of my medical information to _____ (circle relationship) Spouse Daughter Son Parent Other

SIGNATURE OF RESPONSIBLE PARTY X _____ DATE _____

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