

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

JOSHUA D. MUNRO M.D.

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www.drmunrosoffice.com

PATIENT INFORMATION
CHILD HISTORY

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

Please Print

TODAY'S DATE

Form section containing patient identification and contact information: CHILD'S NAME (LAST, FIRST, MIDDLE), 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?

Table titled 'HEALTH OF FAMILY' with columns: FAMILY MEMBER, GOOD, POOR, DIED, IF DIED, NOTE AGE AND CAUSE (INCLUDES FATAL ACCIDENTS AND SUICIDES). Rows include FATHER, MOTHER, BROTHERS & SISTERS, SPOUSE, CHILDREN.

Form section titled 'ILLNESS' with the instruction: IF YOU HAVE HAD ANY OF THE FOLLOWING, CHECK THE APPROPRIATE BOX. Includes checkboxes for MUMPS, MEASLES, CHICKEN POX; RUBELLA, GERMAN MEASLES; and RHEUMATIC FEVER.

Table titled 'HOSPITALIZATIONS / SURGERY' with the instruction: LIST ILLNESS OR OPERATION, AND APPROXIMATE YEAR. Includes columns for Year.

Form section titled 'MEDICINE ALLERGIES' with the instruction: LIST ALL MEDICATIONS YOU ARE ALLERGIC TO.

Form section titled 'MEDICINES' with the instruction: LIST ALL MEDICINES, BIRTH CONTROL PILLS, OR VITAMINS YOU TAKE WITH OR WITHOUT A PRESCRIPTION.

Large immunization record table with columns for DATE, MATERIAL, RESULT, PHYSICIAN, and specific diseases: DIPHTERIA, WHOOPING COUGH, TETANUS, and a large COMMENTS column.

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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TODAY'S DATE \_\_\_\_\_

CHILD'S NAME (LAST)		FIRST	MIDDLE	<input type="checkbox"/> FEMALE <input type="checkbox"/> 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				IF DIED, NOTE AGE AND CAUSE (INCLUDES FATAL ACCIDENTS AND SUICIDES)	ILLNESS		
FAMILY MEMBER	GOOD	POOR	DIED		IF YOU HAVE HAD ANY OF THE FOLLOWING, CHECK THE APPROPRIATE BOX.		
FATHER (Natural, biological)					<input type="checkbox"/> MUMPS, MEASLES, CHICKEN POX	<input type="checkbox"/> RUBELLA, GERMAN MEASLES	<input type="checkbox"/> RHEUMATIC FEVER
MOTHER (Natural, biological)							
BROTHERS & SISTERS:							
SPOUSE							
CHILDREN							

MEDICINE ALLERGIES				HOSPITALIZATIONS / SURGERY		
LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:				LIST ILLNESS OR OPERATION, AND APPROXIMATE YEAR.		
				Year	Year	
				Year	Year	
MEDICINES				MEDICINES		
LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:				LIST ALL MEDICINES, BIRTH CONTROL PILLS, OR VITAMINS YOU TAKE WITH OR WITHOUT A PRESCRIPTION:		

		DIPHTHERIA	WHOOPIING COUGH	TETANUS								COMMENTS
DATE												
MATERIAL												
RESULT	DATE	AGE GIVEN										
PHYSICIAN												
DATE												
MATERIAL												
RESULT												
PHYSICIAN												
DATE												
MATERIAL												
RESULT												
PHYSICIAN												
DATE												
MATERIAL												
RESULT												

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

SIGNATURE OF RESPONSIBLE PARTY **X** \_\_\_\_\_ DATE \_\_\_\_\_