RIVER PEDIATRIC CLINIC INTAKE FORM

PATIENT & CONTACT INFORMATION

Name (First and Last):	Age:	Gender: ❒ Girl ❒ Boy ❒ Transgender ❒ Nonbinary ❒ Prefer not to answer	Pronouns: ❒ She/her ❒ He/him ❒ They/them ❒ _____

Race: ❒ White ❒ Black / African American ❒ American Indian / Alaska Native
❒ Native Hawaiian / Other Pacific Islander ❒ Prefer not to answer

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Prefer not to answer

Home Address:

Parent/Guardian 1 Information	Parent/Guardian 2 Information
Name: _____	Name: _____
DOB: _____	DOB: _____
Phone: _____	Phone: _____
Email: _____	Email: _____
Address: _____ ❒ Address same as patient	Address: _____ ❒ Address same as patient
Occupation:_____	Occupation:_____
Emergency Contact? ❒ Yes ❒ No	Emergency Contact? ❒ Yes ❒ No
Relationship to Patient: ❒ Mother ❒ Father ❒ Other	Relationship to Patient: ❒ Mother ❒ Father ❒ Other

Primary Insurance Provider:
❒ Kaiser ❒ Blue Shield ❒ Aetna ❒ Anthem Blue Cross ❒ MediCare ❒ MediCal
❒ Other: _____ ❒ No Insurance

All services provided at RIVER Pediatric Clinic are free of charge, however we may use this information to help patients access services unavailable at our clinic.

Does the patient have a pediatrician or primary care provider? ❒ Yes ❒ No

Name of Pediatrician: _____

Address: _____

Phone Number: _____

Last Appt: _____ Frequency of Visits: ❒ weekly/monthly ❒ annually ❒ less than annual

Preferred Pharmacy: _____
(Name & Address)

LANGUAGE PREFERENCE

Primary Language(s) Spoken at Home: ❒ English ❒ Spanish ❒ Other: _____

Language Preference: _____

Parent/ Guardian Signature: _____ Date: _____

VACCINATION HISTORY FORM

Please fill out the following form for our professionals to assess whether your child has received all necessary vaccinations.

PATIENT CONTACT INFORMATION	
Name:	Birth Date (DD/MM/YY):

VACCINATION INFORMATION

Mark all of the following that apply:

Hepatitis B ❒ #1 ❒ #2 ❒ #3 Administered on (list all dates): _____

Rotavirus ❒#1 ❒ #2 ❒#3 Administered on (list all dates): _____

DTaP ❒#1 ❒ #2 ❒#3 ❒ #4 Administered on (list all dates): _____
_____

HIB ❒#1 ❒ #2 ❒ #3 Administered on (list all dates):
_____
_____

PCV 13 or 15 ❒#1 ❒ #2 ❒ #3 ❒ #4 Administered on (list all dates): _____
_____

Polio (IPV) ❒#1 ❒ #2 ❒ #3 Administered on (list all dates): _____
_____

COVID-19 ❒#1 Boosters? Y/N Administered on (list all dates): _____
_____

❒ Influenza Administered on (list all dates): _____
_____

❒ MMR (measles, mumps, rubella) Administered on (list all dates): _____
_____

❒ Varicella Administered on (list all dates): _____
_____