PEDIATRIC INFECTIOUS DISEASES
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HackensackUMC
Pediatric Infectious Diseases

Pediatric Infectious Diseases New Patient Intake

Today's Date: _____ Is there a specific physician you would like to see? _____

Identifying Information:

Patient's Name: _____DOB: _____ M F

Caller's Name: _____ Relationship: _____

Address: _____

_____

Home Phone: _____ Alternate: _____

Fax or email: _____

Referring physician: _____ Phone: _____

Symptoms; Complaints; Testing that has been done:

Why is the child being referred? _____

For travel visits only: Destination(s): _____ Date of trip: _____ (skip to insurance information)

Child's weight: _____

Fever?	Y	N	For how long? _____
Rash?	Y	N	Where? _____
Cough?	Y	N	For how long? _____
Vomiting or Diarrhea?	Y	N	For how long? _____
Swelling?	Y	N	Where? _____
Is there any pain?	Y	N	Where is the pain located? _____
Other symptoms?	Y	N	What? _____
Labs or X-rays done?	Y	N	Results? _____

Insurance Information:

Insurance: _____

ID#: _____ Group#: _____

Do you need a referral? Y N

Co-pay: Y N How much? _____

Subscriber's Name: _____ DOB: _____

Relation to child: _____ SS#: _____

Place of Employment and Address: _____

Insurance Address: _____

_____ Phone: _____

For Office Use Only

Appointment Date and Time:_____ Doctor: _____

___ Patient notified & accepted appointment ___ Directions Sent
___ Pre-registration/In SMS ___ Booked in IDX
___ Told to bring copy of immunization records (travel)
___ Told to bring all lab and radiology testing at the time of the appointment or
___ Patient told to have referring physician's office fax all testing results
___ Marked on physician's Outlook calendar for staffing or "Off-days"

Person that has completed all of above: _____Reviewed by Dr: _____

Sooner appointment needed? Y N OK as booked? Y N

Comments or changes needed? _____