PEACOCK PEDIATRICS
ADULT NEW PATIENT REGISTRATION FORM
(PLATTE CITY LOCATION ONLY)

All areas in the form are required to be completed and must be received before scheduling occurs.
Please email all adult registration forms to our Platte City email: plattecity@peacockpediatrics.com

Date:_____

Transferring from: Office/Dr. _____
Address: _____
_____
_____
Phone: _____ Fax: _____

Requested Provider (Circle): Dr. Carmen Ford Genese Marshall, APRN

Patient:

Last Name_____ First Name_____ Middle_____
Date of Birth: _____ (Circle) Gender: M / F
Address:_____City:_____State: _____Zip:_____
Phone:_____
Email: _____ Would you like Patient Portal access? Y / N

MEDICAL HISTORY/DIAGNOSIS: #1_____ #2_____ #3_____
CURRENT MEDICATIONS: #1_____#2_____#3_____
ANY CONCERNS? _____
INSURANCE: Primary _____ Member/Subscriber #_____
Secondary_____ Member/Subscriber #_____
RACE_____ETHNICITY_____LANGUAGE_____

Family/Emergency Contacts:

Last Name_____ First Name_____ Middle_____
Date of Birth: _____ (Circle) Gender: M / F Relationship: _____
Address:_____City:_____State: _____Zip:_____
Phone:_____

Last Name_____ First Name_____ Middle_____
Date of Birth: _____ (Circle) Gender: M / F Relationship: _____
Address:_____City:_____State: _____Zip:_____
Phone:_____

Peacock Staff Use Only_____
ACCEPTED: Y/N Dr. F_____Genese_____ DATE: _____

Patient Name: _____ Date of Birth: _____

Personal Health History Information

Past Medical History:

List all previous and current medical conditions:

_____

_____

List any surgeries: _____

List all allergies: _____

List all current medications and dose:

_____

_____

Health Maintenance History:

Screening Test	Approx Date:	Screening Test	Approx Date
Mammogram		Dexa Scan	
Pap smear		PSA test	
Colonoscopy		Eye exam	
Cholesterol		Dental exam	

Health Habits:

Exercise: _____ Frequency: _____

Tobacco/Vape Use: _____ # Years: _____ #Packs/Day: _____

Alcohol Use: _____ Frequency: _____

Recreational Drug Use: _____ Frequency: _____

Marijuana Use: _____ Frequency: _____

Family History:

Family Member	Medical conditions
Mother	
Father	
Maternal Grandfather	
Maternal Grandmother	
Paternal Grandfather	
Paternal Grandmother	
Sibling Circle one: M / F	
Sibling Circle one: M / F	
Sibling Circle one: M / F	