



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? _____
PREFERRED PHARMACY? _____
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: _____

Peacock Staff Use Only
ACCEPTED: Y/N Dr. F Genese DATE: _____



Peacock Pediatrics – Affiliate of Children’s Mercy
1300 Plaza Court, Platte City, MO 64079
P: 816.422.2300 F: 816.398.6896

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	