Pediatric Healthcare Associates

ADOPTION PRE-VISIT ON: _____

Parent 1:_____
(First) (Last) (DOB)

Parent 2: _____
(First) (Last) (DOB)

Address: _____

Home Phone: _____ Cell Phone: _____

Referred by: _____

Occupation: _____
(Parent 1) (Parent 2)

Medical Insurance & Policy #: _____

Child's History:

DOB: _____

Country of Origin: _____

Date of Adoption: _____

Medical Records Available? _____

Immunization Records? _____

Known Medical Issues: _____

Known Developmental Issues: _____

Any other children in your family? ☐ yes ☐no

If yes, ages and gender: _____

_____