Jenny Saw, M.D.
Pediatrics

200 Jose Figueres Ave, Suite 455
San Jose, CA 95116
Tel: (408) 923-8522 Fax: (408) 923-8709

PATIENT REGISTRATION

Patient's Information:

Patient's Name:_____________________________ [ ] Male [ ] Female Date of Birth:____________________
Home Address:___________________________________City:_____________________ Zip Code:___________
Home Phone:____________________ Father's Cell:____________________ Mother's Cell:__________________
Email Address:___________________________________

Parent's or Guardian's Information

Father's Name:________________________ Date of Birth:____________Soc. Security#:____________________
Employer: ____________________________Work Phone:____________ Occupation:______________________
Mother's Name:________________________Date of Birth:___________ Soc. Security#:____________________
Employer: ____________________________Work Phone:____________ Occupation:_______________________

Language Spoken: ___________________________

Insurance Information

Primary Insurance:_____________________________ Secondary Insurance:______________________________

Health History

Check the following if your child has any of the following problems:

[ ] TB Contact [ ] Ear Infection [ ] Ear/Hearing Problem [ ] Eye/Vision Problems
[ ] Seizures [ ] Speech Problems [ ] Asthma [ ] Heart Problems
[ ] Surgery [ ] Hospitalization [ ] Allergies to Medicine or Food [ ] Problems at Birth
[ ] Other Concerns:____

For Newborn Baby

Labor & Delivery: Normal / Forceps / Vacuum / Caesarian Section / Longer than 12 hours
Birth Weight: _____ lbs. _____ oz. Birth Height: _______ in. Head Circumference: _________ cm.

Prenatal History

Did your baby come on time? Yes / No If No, how early/late?____________________________________
Did you have any health problems during pregnancy? Yes / No Please list:___________________________
Did you use any of the following during pregnancy: [ ] cigarettes [ ] alcohol [ ] prescriptions
[ ] Vitamins [ ] drugs [ ] home remedies

Family History

Check any illness a family member or relative has had:

[ ] tuberculosis [ ] high blood pressure [ ] heart disease [ ] diabetes [ ] high cholesterol
[ ] asthma [ ] seizures [ ] mental illness [ ] cancer [ ] others:______________________

Authorization

I hereby give Dr. Saw permission to administer the necessary medical treatment and immunization to my child, I hereby authorize Dr. Saw to furnish information to insurance carriers concerning the illness/accident, and assign to the doctor all payments for medical services rendered.

Signature of Parent / Guardian: ____ **Date:** ___________________