FAIRPORT
PEDIATRICS, LLP

New Patient Transfer-In Form

Thank you for your interest in joining our practice! Please take a few minutes to complete this form so that we may ensure a smooth transition for your family. We look forward to meeting you!

Are you new to the area? YES / NO

How long were you at your current practice? _____

Why are you leaving that practice?_____

What is important to you/ your family when establishing care with a pediatrician?_____

_____

When was your child's/ children's last physical exam? _____

Are you in need of a physical/ medication refill within 1 month? _____

Are any of your children on any maintenance medication(s)? YES / NO

Name of medication(s):_____

When will they be due for a refill:_____

Are your children up to date with their immunizations? If not, please explain: _____

_____

I hereby certify that the information provided above is true and accurate. I also acknowledge that the practice and all providers at Fairport Pediatrics require adherence to the American Academy of Pediatrics (AAP) recommended vaccine schedule. If, at any time, I decide to delay or refuse the AAP recommended vaccines, I understand that this may result in my dismissal from the practice.

Parent Signature:_____ Date:_____

Parent name (printed):_____

Please send completed form to our office either by mail or by e mail to hnorsen@fairportpediatrics.com. Please note, the requested provider will review the form and reserves the right to approve or deny your request.