



PATIENT INFORMATION

Date: _____

Child's Name: _____ (Last Name) _____ (First Name) _____ (M.I.) SEX: Male Female

Date of Birth ____/____/____ Age _____ Child's SSN#: _____
Month Day Year (To be used for immunization registry)

Address _____ City _____

State ____ Zip Code _____ Home Phone # _____ Cell Phone # _____

Previous records may be obtained from _____ Phone # _____

Other siblings (names & ages) _____

Email address _____

How did you hear about us? Insurance School Relative Friend Other _____
(Please specify)

Pharmacy Name _____ Phone # _____

Address _____ City _____

State ____ Zip Code _____

INSURANCE INFORMATION *Does the patient have medical insurance? Yes No

If yes, Insurance Name _____ I.D. # _____

Policy Holder _____

In Case of Emergency (Not living with you)

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

PARENT INFORMATION

Mother's Name _____	Father's Name _____
SSN # _____	SSN # _____
Driver's License # _____	Driver's License # _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Phone # _____	Phone # _____
Employer _____	Employer _____
Employer Phone # _____	Employer Phone # _____

Patient _____ DOB _____ Today's Date _____



- | | | | |
|--------------------------------------|---|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hernia | <input type="checkbox"/> RSV |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Speech Delay |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Intestinal Parasites | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Febrile Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tonsillar Hypertrophy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fracture _____ | <input type="checkbox"/> Lacrimal Disorders | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Otitis Media/Serous | <input type="checkbox"/> Other _____ |

HOSPITALIZATIONS

Hospital	Dates	Reason(s)

MEDICATION HISTORY (list any current medications be taken by patient)

ALLERGIES

- DRUG:** Acetaminophen Ibuprofen Penicillin Macrolides Sulfas Other: _____
- FOOD:** Eggs Chocolate Milk Shellfish Strawberries Other: _____
- ENVIRONMENT:** Animal Dander Dust Grasses Latex Pollen Other: _____

SOCIAL HISTORY

Smoker in the home: Yes / No	# of Adults in Household:	Patient lives with:
Pets in the home: Yes / No	# of Children in Household:	Patient Attends: <input type="checkbox"/> Daycare <input type="checkbox"/> School <input type="checkbox"/> Babysitter <input type="checkbox"/> Stays home

SURGICAL HISTORY

Date	Reason

OTHER PERTINENT PATIENT HISTORY

Patient: _____ DOB _____ Today's Date _____

FAMILY HISTORY

- Anemia :** Yes No **Heart Disease/Stroke** Yes No **Asthma:** Yes No
- Disabled:** Yes No **Emotional Disease** Yes No **Social Problems:** Yes No



Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Retardation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Diseases:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoker:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bloody Dyscrasias:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Defects:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcoholism:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/Urinary Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Abuse Situation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other problems: _____ Type of Allergy: _____

MOTHER'S PRENATAL HISTORY

High B/P:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rubella:	<input type="checkbox"/> Yes <input type="checkbox"/> No
STD (specify _____):	<input type="checkbox"/> Yes <input type="checkbox"/> No	OTC Drugs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hubs Ag:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Street Drugs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
X-ray:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prescriptions:	_____	Mother's Blood Type:	_____

Any problems/complications during pregnancy: _____

Trimester /Date Prenatal care began: _____

DELIVERY AND NEONATAL PROBLEMS & CONDITIONS

<input type="checkbox"/> Spontaneous Vaginal Delivery	<input type="checkbox"/> Prolonged labor	<input type="checkbox"/> Breech	<input type="checkbox"/> PROM
<input type="checkbox"/> Precipitous Delivery	<input type="checkbox"/> Forceps	<input type="checkbox"/> Caesarean Delivery	<input type="checkbox"/> Tremor
<input type="checkbox"/> Deformities	<input type="checkbox"/> Injuries	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Cardiac
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Irritability	<input type="checkbox"/> Feeding
<input type="checkbox"/> Incubator _____ days	PKU done? <input type="checkbox"/> Yes <input type="checkbox"/> No	Apgar Score: _____	Birth Weight: _____

Any delivery problems/complications? _____ Length of stay in hospital? _____

Any significant illness including hospitalization, emergency room visits, specialist consults since birth? Yes No

If yes, please explain: _____

Any speech therapy, special education, physical therapy, use of Ritalin, seizure disorder, etc? Yes No

If yes, please explain: _____

Signature: _____ Date: _____ Relationship with patient: _____



FINANCIAL ASSIGNMENT AND AGREEMENT

Patient Name _____ DOB _____ Parent/Guardian _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is **NOT** a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance**

/ HMO/ PPO plan.

**IN ORDER TO CONTROL YOUR COSTS, PAYMENTS FOR SERVICES RENDERED ARE EXPECTED TO BE
PAID AT THE TIME OF SERVICE.**

1. I authorize any holder of medical information about me to release the Health Care Financing Administration, its agent, or any insurance carrier or plan I may have, any information needed to determine these benefits payable for related services.
2. **If my Insurance/Medicare/Medicaid/HMO/PPO does not cover my care at Soma Medical Center P.A #4. I agree to personally pay for all services rendered. I acknowledge that it is my responsibility to know my plan's coverage and inform Soma Medical Center P.A #4. of any changes in coverage.**
3. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original.
4. **IF NO INSURANCE:** I understand and agree that I am responsible for all charges incurred regarding my medical treatment and that I will make payment at the time of service.
5. If unable to keep appointment, kindly give 24 hours notice otherwise \$20.00 will be charged.

Patient / Parent / Guardian Signature: _____

Patient / Parent / Guardian Name: _____ Date: _____

Witness Signature: _____

Witness Name: _____ Date: _____



CONSENT BY PROXY

I (we) appoint _____
(Full Name) (Address)

who is my (our) child(ren)'s _____ as my (our) proxy decision maker
(specify nature of proxy's relationship to child(ren))

for consenting to nonurgent medical care for my (our) children listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

LIMITATIONS

Identify any limitation on the kinds of medical services for which this consent by proxy is given. If none, state "none."

Identify any limitation on the time frame for which this consent by proxy is given. If none, state "none."

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____

Parent's Name: _____

Daytime Phone: _____

Daytime Phone: _____

Evening Phone: _____

Evening Phone: _____

Cell Phone: _____

Cell Phone: _____

Parent or Legal Guardian

Parent or Legal Guardian Signature

Parent or Legal Guardian

Parent or Legal Guardian Signature

Proxy Decision Maker

Driver's License Number of Proxy Decision Maker



HIPPA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

RECORDS ON (PATIENT NAME) _____ **(DOB)** _____

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

RECORDS MAILED FROM: _____

The following person or class of persons may receive disclosure of protected health information about me.

RECORDS MAILED TO: Soma Medical Center P.A #4
10131 Forest Hill Blvd. Suite 140
Wellington, FL 33414
Telephone: (561) 513-9030 Fax: (561) 793-4375

Specific description of information to be released (must include date(s) of service):

The information to be released will be used for the purpose described below:

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying **Soma Medical Center P.A #4** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____, or 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual

Date of Signature

Date of Birth or SS Number

• ***OR, if applicable-***

Signature of Guardian

Date of Signature

Description of Guardian's
Personal Representative's
Authority to Act for the
Individual