SOMA
MEDICAL CENTER, P.A. #2

PATIENT INFORMATION

Date: _____

Child's Name: _____ _____ ____ SEX: ___Male ___Female
(Last Name) (First Name) (M.I.)

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 #_____

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Patient_____**DOB**_____**Today's Date**_____

PATIENT'S PERTINENT MEDICAL HISTORY (check all those that apply)

□ ADHD	□ Diabetes	□ Heart Murmur	□ Pneumonia
□ Allergies	□ Ear Infections	□ Hernia	□ RSV
□ Anemia	□ Eczema	□ Influenza	□ Speech Delay
□ Asthma	□ Epilepsy	□ Intestinal Parasites	□ Thyroid Disorder
□ Autism	□ Febrile Seizures	□ Kidney Problems	□ Tonsilar Hypertrophy
□ Bronchitis	□Fracture _____	□ Lacrimal Disorders	□ UTI
□ Cholesterol	□ GERD (reflux)	□ Otitis Media/Serous	□ 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: □Daycare □School □Babysitter □Stays home

SURGICAL HISTORY

Date	Reason

OTHER PERTINENT PATIENT HISTORY

_____

_____

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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:	□ Yes □ No	**Seizures:**	□ Yes □ No	**Tuberculosis:**	□ Yes □ No
Epilepsy:	□ Yes □ No	**Diabetes:**	□ Yes □ No	**Mental Retardation:**	□ Yes □ No
Lung Diseases:	□ Yes □ No	**Smoker:**	□ Yes □ No	**Bloody Dyscrasias:**	□ Yes □ No
Birth Defects:	□ Yes □ No	**Alcoholism:**	□ Yes □ No	**Kidney/Urinary Disease**	□ Yes □ No
Child Abuse Situation:	□ Yes □ No	**Drug Addiction:**	□ Yes □ No	**Allergies:**	□ Yes □ No

Other problems:_____ **Type of Allergy:** _____

MOTHER'S PRENATAL HISTORY

High B/P:	□ Yes □ No	**Alcohol**	□ Yes □ No	**Rubella:**	□ Yes □ No
STD (specify_____):	□ Yes □ No	**OTC Drugs:**	□ Yes □ No	**Hubs Ag:**	□ Yes □ No
Tobacco:	□ Yes □ No	**Diabetes:**	□ Yes □ No	**Street Drugs:**	□ Yes □ No
X-ray:	□ Yes □ No	**Prescriptions:**_____		**Mother's Blood Type:** _____	

Any problems/complications during pregnancy:_____

Trimester /Date Prenatal care began:_____

DELIVERY AND NEONATAL PROBLEMS & CONDITIONS

□**Spontaneous Vaginal Delivery**	□ **Prolonged labor**	□ **Breech**	□ **PROM**
□ **Precipitous Delivery**	□ **Forceps**	□ **Caesarean Delivery**	□ **Tremor**
□ **Deformities**	□ **Injuries**	□ **Respiratory**	□ **Cardiac**
□ **Jaundice**	□ **Oxygen**	□ **Irritability**	□ **Feeding**
□ **Incubator ____days**	**PKU done?** □ **Yes** □ **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? o Yes o No

If yes, please explain:_____

Signature:_____Date:_____Relationship with patient:_____

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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 Administrat ion, 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 #2.** 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 #2. 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:_____

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CONSENT BY PROXY

I (we) appoint _____

(Full Name) (Address)

who is my (our) child(ren)'s _____ as my (our) proxy decision maker
(specify natur e of proxy's relatio nship t o child(r en)

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 informati on 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 natu r e 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: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Par ent's Name: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

_____
Parent or Legal Guardian

_____
Parent or l egal Guardian Signature

_____
Parent or l egal Guardian

_____
Parent or l egal Guardian Signature

_____
Proxy Decision Maker

_____
Driver's li cense Number of Proxy Decision Maker

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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 #2
2135 South Congress Avenue Suite 3C
Palm Springs, Fl 33406
Telephone: (561) 360-2034 Fax: (561) 360-2650

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 #2** 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