PATIENT INFORMATION

Date: ____________________

Child's Name: ____________________ (Last Name) ____________________ (First Name) ___ (M.I.) SEX: ___Male ___Female

Date of Birth _____/_____/________ (Month Day Year) Age_______ Child's SSN#: ____________________ (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	Father
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**_______________

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

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

____

____

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:_______________________

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 #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 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

HIPAA 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
1840 Forest Hill Blvd. Suite 101
West Palm Beach, Fl 33406
Telephone: (561) 964-1181 Fax : (561) 964-1196

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