

# Pediatric Registration Form



## Internal Medicine & Pediatrics of Tampa Bay

### Patient Information

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ M / F  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Home Address: \_\_\_\_\_ \*\*Primary Phone #: \_\_\_\_\_ Home Cell  
\_\_\_\_\_ Alternate Phone #: \_\_\_\_\_ Home Cell  
E-mail Address: \_\_\_\_\_ (used for office update information only)

**\*\* Please note - primary # will be used for confirmation calls, billing inquiries and lab or test results.  
We will leave a voicemail if unable to speak directly with you.**

**Mother's Name** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Social Security #: \_\_\_\_\_  
\_\_\_\_\_ Primary Phone #: \_\_\_\_\_ \*\*  
\_\_\_\_\_ Alternate Phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Employer address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
\_\_\_\_\_

**Father's Name** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Social Security #: \_\_\_\_\_  
\_\_\_\_\_ Primary Phone #: \_\_\_\_\_ \*\*  
\_\_\_\_\_ Alternate Phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Employer address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
\_\_\_\_\_

### Insurance information

Insurance Company Name: \_\_\_\_\_ Policy Type: HMO PPO PPC Other  
Telephone #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_

Full Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (Insured)  
Social Security# (Insured) \_\_\_\_\_ Relationship to Patient: Self Spouse Child (circle one)

Do you have secondary insurance? Yes No If Yes, Insured Name: \_\_\_\_\_  
Ins. Carrier Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Grp: \_\_\_\_\_

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### **Please read the following statements and sign below:**

*I understand that payment of all medical care is due and payable at the time of service. I understand that it is my responsibility to pay a deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's account in case of default, including reasonable attorney fees and court costs.*

*I hereby grant permission to Internal Medicine & Pediatrics of Tampa Bay, PA to release any pertinent information to my insurance company upon request, and I also authorize payments directly to Internal Medicine & Pediatrics of Tampa Bay. A photo static copy of this authorization shall be considered as effective and valid as the original.*

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Internal Medicine & Pediatrics  
of Tampa Bay**

**Consent for Release of Medical Information / Permission for Medical Treatment**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that my child's medical information is confidential and can not be released without my authorization. I authorize Internal Medicine & Pediatrics of Tampa Bay to release my medical information to the following individuals both verbal and written:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

In addition, please list all persons who may have permission to bring the patient in for medical care and sign consent for any vaccine administration.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

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**Emergency Contact Information**

Who should we contact in case of an emergency if you cannot be reached? Please list someone who does not reside with the patient.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient: \_\_\_\_\_

DOB: \_\_\_\_\_



## Internal Medicine & Pediatrics of Tampa Bay

### Patient Medical History

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**Confidentiality Disclaimer:** All of the following information is confidential and may not be reproduced or distributed without patient permission with the exception to those individuals listed (if any) and as allowed by law according to the notice of privacy practices.

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#### **Prenatal / Birth History** - If less than 1 year old

Where did the mother receive prenatal care? \_\_\_\_\_

Were there any complications during the pregnancy? \_\_\_\_\_

Was the mother using tobacco, alcohol, or medications during any part of the pregnancy?  
\_\_\_\_\_

Where was the child born? \_\_\_\_\_

What was the baby's birth weight? \_\_\_\_\_ Full term or Premature (Circle one)

What type of delivery?      Vaginal      C-section

Were there any complications during or after the delivery? \_\_\_\_\_

If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

#### **Review of systems.**

Please circle any of the following items that are a recurrent problem for the patient. (not acute issues)

poor tone/weakness  
poor feeding  
weight loss or gain  
history of poor growth  
recurrent fevers  
vision problems  
eye discharge  
hearing problems  
chronic ear infections  
nasal discharge  
nose bleeds  
chronic congestion  
recurrent infections  
frequent sore throats

chest pain  
history of heart murmur  
cough  
wheezing  
shortness of breath  
nausea or vomiting  
abdominal pain  
diarrhea or constipation  
blood or mucus in stools  
blood in urine  
multiple UTIs  
rash  
acne  
aggressive behavior

hyperactivity  
learning disability  
dizziness  
headaches / migraines  
seizures  
depression  
anxiety  
difficulty sleeping  
enlarged lymph nodes  
bruising  
history of anemia  
limping / difficulty walking  
muscle aches  
neck or back pain

**General Medical History**

Please list previous and current **medical issues**, including **hospitalizations, surgeries,** and **procedures**. Please list dates if known.

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Please list any **medications** is the patient currently taking: (Please include dose and frequency)  
(Please include any herbals and over the counter meds)

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Please list any **allergies**, and the type of reaction.

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**Social History:**

Who does the patient live with? \_\_\_\_\_

Are there any pets at home? \_\_\_\_\_ If so, what kind? \_\_\_\_\_

Does the patient go to daycare or attend school? \_\_\_\_\_

Does anyone at home smoke tobacco? \_\_\_\_\_

**Family History.**

Do any family members suffer from the following? Please check Yes or No.

	Yes	No
High Blood Pressure		
Heart Disease		
High Cholesterol		
Strokes		
Diabetes		
Thyroid disease		
Cystic fibrosis		
Sickle cell disease		

	Yes	No
Asthma		
Seizures		
Kidney Disease		
Gastrointestinal Disease		
Arthritis		
Cancer		
Mental Retardation		
Genetic Defects		

For any Yes responses, please describe: \_\_\_\_\_

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How did you hear about our practice? \_\_\_\_\_

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**ALL PATIENTS:**

*This is to acknowledge that Internal Medicine & Pediatrics of Tampa Bay, PA has provided a Notice of Privacy Practices for me to review.*

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for choosing Internal Medicine & Pediatrics of Tampa Bay!**