Pediatric New Patient Form

Internal Medicine & Pediatrics

Patient Information

Today's Date: _____

Legal Name: _____ Gender: M / F

Date of Birth: _____ Age: _____ Race :_____

Ethnicity: _____

E-mail Address: Other:____ _____

_____

Home Address: _____ Primary Telephone #: _____

_____ HOME CELL **CIRCLE ONE**

_____ Secondary Telephone _____

HOME CELL **CIRCLE ONE**

****Your contact phone #'s will be used for appointment confirmation calls, billing inquiries and lab or test results. We will leave a voicemail if unable to speak directly with you.**

Parent#1 Name _____ Date of Birth: _____

Home Address : _____ Primary Phone : _____
(if different) HOME CELL **CIRCLE ONE**

(if different) _____ Secondary Telephone : _____
(if different) HOME CELL **CIRCLE ONE**

Employer: _____ Work Phone #: _____

Parent#2 Name _____ Date of Birth: _____

Home Address : _____ Primary Phone : _____
(if different) HOME CELL **CIRCLE ONE**

(if different) _____ SecondaryTelephone # _____
(if different) HOME CELL **CIRCLE ONE**

Employer: _____ Work Phone #: _____

Form Completed By:

Name (*print*) _____ **Signature:**_____

Print Patient Name:_____ Date of Birth: _____

Release of Medical Records / Permission for Medical Treatment

I _____ authorize Internal Medicine & Pediatrics of Tampa Bay
print name of legal guardian
and it's personnel to deliver medical services to my child, listed above.

In addition, please list all persons who may have permission to bring patient in and authorize medical care.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please list all persons (if any) who you will allow verbal or written access to the patient's medical records.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

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 # _____

_____ Date:_____
Signature of Parent/Legal Guardian

_____
Relationship to patient

Print Patient Name:_____ Date of Birth: _____ Pg 3

Insurance information

Insurance Plan Name: _____ Effective Date: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ Relationship:_____

Do you have secondary insurance? Yes No

Insurance Plan Name: _____ Effective Date: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ Relationship:_____

*****NOTICE** Physician and staff are not responsible for determining if practice is in or out of network with your insurance plan. I understand I must contact my insurance to determine my benefits and coverage for care at this office. Initial _____**

I hereby grant permission to Internal Medicine & Pediatrics of Tampa Bay to release any pertinent information to my insurance company upon requests, and I also authorize payment directly to Internal Medicine & Pediatrics of Tampa Bay, PA. A photcopy of this authorization shall be considered as effective and valid as the orginial.

_____ _____ _____

Responsible Party Signature **Print Name** **Date**

Print Patient Name:_____ Date of Birth: _____

NOTICE OF FINANCIAL RESPONSIBILITY

Please read the following statements and sign below:

I understand that payment of all medical care is due at the time of service. The parent and/ or legal guardian who signs this form is responsible for any and all co-pays, deductibles co-insurance, fees and /or unpaid balances not covered by my insurance.

Please note Internal Medicine & Pediatrics of Tampa Bay will collect all copayments, co-insurances,and deductible at the time of service, unless prior arrangements have been made with the billing department.

Appointments missed, cancelled or rescheduled with less than 1 business day notice will be subject to a possible $25.00 fee.

I understand that I am responsible for any cost incurred in the collection of a patients' account in case of default, including any reasonable fees and court costs.

Divorce / Child Custody

Internal Medicine & Pediatrics of Tampa Bay, PA will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Degree from Judgement or the like (the "Arrangements"). Since Internal Medicine & Pediatrics of Tampa Bay is not a party to these arrangements it is not obligated to the financial terms of these Arrangements.

If the child is on the non-custodial or non presenting parent's health insurance, then Internal Medicine & Pediatrics of Tampa Bay will still collect the applicable co-pays, coinsurance, and deductibles at the time of services from the presenting parent or legal guardian.

Upon request, Internal Medicine & Pediatrics of Tampa Bay will provide a duplicate copy of your receipt so that the Presenting parent or guardian can seek reimbursement where appropriate.

☐ **I acknowledge that Internal Medicine & Pediatrics of Tampa Bay, PA has provided a Notice of Privacy Practices for me to review. I understand that I may receive a copy of the current Notice upon request.**

☐ **I have read all of the above and understand/agree to all provisions therein regarding finacial responsibility, permission to treatment, and Notice of Privacy Practice.**

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Responsible Party Signature / Contact Information

_____ _____

Responsible Party Name (print) **Date of Birth (mm/dd/yyyy)**

_____ _____

Address / City / State / Zip **Primary Phone Number**

_____ _____ _____

Responsible Party Signature **Social Security #** **Date**

Thank you for taking the time to fill out this form.

Print Patient Name:_____ Date of Birth: _____

Prenatal / Birth History

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?

What type of delivery? Vaginal C-section

Were there any complications during or after the delivery?

If so, please describe:

General Medical History

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

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

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

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?

Print Patient Name:_____ Date of Birth: _____

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:

Review of systems.

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

poor tone / weakness	chest pain	hyperactivity
poor feeding	history of heart murmur	learning disability
weight loss or gain	cough	dizziness
recurrent fevers	shortness of breath	seizures
vision problems	nausea or vomiting	depression
eye discharge	abdominal pain	anxiety
hearing problems	diarrhea or constipation	difficulty sleeping
chronic ear infections	blood or mucus in stools	enlarged lymph nodes
nasal discharge	blood in urine	bruising
nose bleeds	multiple UTIs	history of anemia
chronic congestion	rash	limping / difficulty walking
recurrent infections	acne	muscle aches
frequent sore throats	aggressive behavior	neck or back pain

How did you hear about our practice? _____

Print Patient Name: _ _____ Date: _____

Signature: Patient/Guardian: _____ Relationship: _____