

Patient Insurance/Contact Info Update

Windermere Pediatrics, PA
2101 Park Center Drive
Suite 130
Orlando, FL 32835
Phone: 407-297-0080 Fax: 407-295-3080

Date: _____ Account Number: _____

Patient					
Name (Last, First, MI)	SSN	Age	DOB	Sex	Phone(s)
Mailing address				State	ZIP

Responsible Party				
Name (Last, First, MI)	SSN	Age	DOB	Sex
Mailing address/City	State	ZIP	Ph (H) Ph (M #1) Ph (M #2)	
Employer				
Work Phone:				

Insurance Information			
Subscriber Name, DOB, SSN	Relation	Primary Ins Co Number/Group	Copay
Laboratory Services Provider: <input type="checkbox"/> LabCorp <input type="checkbox"/> Quest Diagnostics <input type="checkbox"/> Florida Pathology Lab <input type="checkbox"/> No preference <input type="checkbox"/> Other (indicate)			

Emergency Contact Information			
Contact name	Relationship	Primary Phone Number	Secondary Phone Number

Siblings with the same responsible party
Name (Last, First, MI)/ DOB/ SSN

Patient release:

I certify that the aforementioned information that I have provided is correct. I authorize the release of my medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OF A FEE AT THE PROVIDERS CURRENT RATE MAY BE CHARGED, on all balances owed to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____
(Signature of insured, authorized person, or parent of patient if minor)

Date _____

Patient - Initial History Questionnaire					
Name (Last, First, MI)			ID NUMBER		
Form Completed by		Date Completed	DOB	AGE	M/F

Please Name all those living in the child's home	Relationship to child	DOB	Health Problems

Are there siblings not listed? If so, please list their names/ages and where they live.

If mother and father are not living together or if the child does not live with parents, what is the child's custody status?

Maternal and Birth History				
Maternal Age at time of Delivery:		Health Status:		
Prenatal Testing Results: Hepatitis B ___ GBS ___ Chlamydia ___ Gonorrhea ___ Syphilis ___ HIV ___		Chromosomal tests:		Abnormal Ultrasound results:
Birth weight	Length	Head	Was delivery vaginal Yes/No	If cesarean, why?
Born at how many weeks gestation?		Did the baby have any problems at birth? Yes/No		Please explain
Was the initial feeding Breast/Bottle		Did your baby go home with mother from the hospital? Yes/No		Did mother have any illness or problems with her pregnancy? Yes/No
During pregnancy, did mother smoke, drink alcohol, use drugs, medications, or have any infections? Yes/No			What?	When?
Hearing test passed at birth? Yes/No			Hepatitis B vac given? Yes/No	Vitamin K given? Yes/No

Child's General Health History:

- Do you consider your child to be in good health? Yes/No Explain _____
- Does your child have any serious illness or condition? Yes/No Explain _____
- Has your child had any serious injuries or accidents? Yes/No Explain _____
- Has your child had any surgeries or accidents? Yes/No Explain _____
- Has your child ever been hospitalized? Yes/No Explain _____
- Is your child allergic to foods, medicines or insects? Yes/No Explain _____

Child's Developmental History:

Are you concerned about your child's physical development? Yes/No Explain _____

Are concerned about your child's mental development? Yes/No Explain _____

Are you concerned about your child's attention span? Yes/No Explain _____

If your child is enrolled in a school:

How is his behavior in school? _____

Has he/she failed or repeated a grade in school _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Additional History:

Please circle and elaborate if anyone in your child has had:

Chickenpox, Frequent ear infections, Hearing problems, Vision problems, Asthma, Bronchitis, Wheezing, Pneumonia, Heart Problems, Heart Murmurs, Anemia, Blood Transfusions, Frequent Abdominal Pain, Constipation, Kidney/Bladder Infection, Bedwetting (over age 10), Skin problems, Frequent Headaches, Convulsions, Diabetes, Thyroid Problems, Alcohol or Substance Abuse.

(For girls) Has your daughter started her menstrual periods? _____

(For girls) Are there problems with her periods? _____

Family History:

Please circle and elaborate if anyone in your family has had:

Deafness, Nasal Allergies, Asthma, Tuberculosis, Heart Disease (before age 50), High Blood Pressure (before age 50), High Cholesterol, Anemia, Bleeding Disorders, Liver Disease, Kidney Disease, Diabetes (before age 50), Bed Wetting (beyond age 10), Epilepsy or convulsions, Alcohol or Substance Abuse, Mental Illness, Developmental Delay, Immunity Problems (i.e. HIV or AIDS),

Additional family health history:

Hospitalizations, Surgeries and Serious Accidents:

What happened?	Hospital	Date	Result

Evaluations:

Type of Specialist	Reason	Date	Result