COMPREHENSIVE
Pediatric & Neonatal
CLINIC

9400 Bonita Beach Rd. SE. STE 204
Bonita Springs, FL 34135
Phone 239 4226020

Patient Information

Patients Name _____ DOB_____

SS # _____ Age _____ Gender: Male / Female

Siblings Name _____

Home Address _____

City / State / Zip _____

Primary Phone #_____ Alternate Phone #_____

May we leave confidential messages at the numbers listed above? _____

Insurance Information

Grantor Name_____ DOB _____ SS # _____

Primary Insurance: _____ ID _____Grp_____

Grantor Name_____ DOB _____ SS # _____

Secondary Insurance_____ ID _____Grp_____

Parent Information

Mother/Parent_____ DOB _____ SS# _____
Birth/Step/Adoptive/Foster
Email Address_____ Primary # _____

Home Address (if different)_____

Occupation_____ Phone #_____

Father/Parent_____ DOB _____ SS# _____
Birth/Step/Adoptive/Foster
Email Address_____ Primary # _____

Home Address (if different) _____

Occupation_____ Phone #_____

Emergency Contact/Additional Persons

Please list all emergency contacts and/or persons who may have permission to bring the patient in for medical care and sign consent for any vaccine administration.

Name	Authorized to bring patient	Phone Number	Relationship to Child
	Yes/No		
	Yes/No		
	Yes/No		

Signature _____ Date _____

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Patient Medical History

Patients Name _____ DOB_____

Pregnancy & Birth Information

Mother's age at birth? ____ Medication during pregnancy? Yes___ No___ **Exclude Vitamins/Iron**_____

Any problems during pregnancy? Excessive Weight Gain___ Excessive Swelling___ UTI___Toxemia___ Venereal Disease___ Other___(please explain)_____

During pregnancy did Mom? Smoke___ Consume Alcohol___ Street Drugs___

At birth, how many gestational weeks was your child? ____ Type of delivery? Vaginal/C-Section

Birth Weight_____ Birth Length _____ Birth Head Circumference_____

Did baby have any complications at birth? Breathing: Yes___ No___ Jaundice: Yes___ No___

Problems after birth? _____

Feeding? Breast Milk____ Formula____ Formula Type_____

Feeding Problems? Colic____ Recurrent Vomiting____ Recurrent Diarrhea____ Multiple Formula Changes____

Has our child ever had any of the following?

o	Measles	o	Mumps	o	Chicken Pox	o	Whooping Cough
o	Scarlet Fever	o	Ear Infections	o	Asthma/Wheezing	o	Eczema/Hives
o	Anemia	o	Hepatitis	o	Seizures	o	Urinary Infections
o	Blood Transfusions	o	Joint Problems	o	German Measles	o	Bleeding Tendency
o	Problems Hearing	o	Problems with Vision	o	Strep Throat	o	Other

Family Medical History

List all blood relatives of your child who have had the following medical problems using the abbreviations listed below:
(F) Father **(M)** Mother **(S)** Sister **(MM)** Mother's Mother **(MF)** Mother's Father **(FM)** Father's Mother **(FF)** Father's Father
(A) Aunt **(U)** Uncle **(C)** Cousin

Anemia/Blood Disorder	Allergies	Alcoholism	Arthritis	AIDS/HIV
Asthma	Allery Shots	Cancer	Cystic Fibrosis	Cholesterol Problem
Birth Defects	Diabetes	Eczema	Ear Tubes	Epilepsy/Seizures
Drug Problem	Early Deafness	Emotional/Behavioral	Growth Problems	Heart Attack/Stroke
Heart Disease	High Blood Pressure	Hereditary Problems	Mental Retardation	Muscular Dystrophy
Migraines	Tuberculosis	School Problems	Sudden Infant Death	Other

Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practice

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.
(patient representative, initial one only)

_____ I reviewed a copy of the Notice of Privacy Practices and have declined a copy.

_____ I reviewed and received a copy of the Notice of Privacy Practice.

Name of Patient (Please Print)

_____

Name of Patient Representative (Please Print)

_____

Signature of Patient, or Patient Representative
(Representative required If the patient Is a minor or an adult unable to sign this form)

_____

Financial Responsibility

ASSUMPTION OF FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible to the doctor for all charges incurred on my account whether covered by my insurance company or not. These charges are to be paid at the time services are rendered unless submitted to an insurance company with whom the Pediatric Group has a participating contract.

I also understand that non-covered services under my insurance policy and outstanding balances become my full responsibility. This may include copays and/or charges incurred for any issue discussed outside my child's growth and development during a well child visit.

In the event collections proceedings are instituted to enforce payment of fees due to the Pediatric Group, I, the undersigned, agree to pay the additional sum of twenty-five (25%) of the principal due as attorney fees, plus all associated court fees.

Please be advised an after-hour charge may apply for appointments after 5pm and on the weekends.

Name of Patient Representative (Print Name)
(Representative required If the patient Is a minor or an adult unable to sign this form)

_____

Signature _____ Date _____

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Office Policies

- Our office does accept walk-in appointments for established/current sick patients upon availability. Please be advised that scheduled appointments will be seen accordingly.
- Our office may terminate a patient after 3 (three) consecutive “no-show” appointments. When canceling please call 24 hours in advance.
- Our office will allow a scheduled patient to arrive up to 5 minutes late. After that you may be required to reschedule your appointment depending on the nature of the visit and/or the availability of the provider you are seeing.
- A parent/guardian choosing to decline vaccinations must sign a "Refusal to Vaccinate" form in order to continue services with our clinic. We reserve the right to dismiss any patients refusing to comply.
- We accept the following forms of payments, which are due at the time of service: Cash, Debit/Credit Cards, Checks.
- Please be advised that any issues discussed outside growth and development during a patient’s well check must be charted by a provider and may result in a copay and/or additional charges.
- Our office reserves the right to dismiss a patient/patient’s family from our practice for making unsubstantiated defamatory statements, whether written or spoken.
- If you are dissatisfied with our services, we take it seriously and invite you to contact our office to resolve the matter and aid us in improving those services.

Signature of Patient, or Patient Representative
(Representative required If the patient is a minor or an adult unable to sign this form)

_____

OFFICE USE ONLY:

Witness Name: _____

Signature: _____

Date: _____

Signature _____ Date _____