

## Patient History

Where was the child born? \_\_\_\_\_ Obstetrician \_\_\_\_\_  
Is the Child Adopted? \_\_\_\_\_ At what age? \_\_\_\_\_ Has he/she been told about the adoption? \_\_\_\_\_  
Full term pregnancy? \_\_\_\_\_ Premature? \_\_\_\_\_ Type of Delivery: \_\_\_\_\_  
Did you take hormones during pregnancy? \_\_\_\_\_  
Problems at birth or in the first few weeks: \_\_\_\_\_  
Birth wt: \_\_\_\_\_ Length \_\_\_\_\_ Head circ. \_\_\_\_\_ Chest circ. \_\_\_\_\_ Apgar \_\_\_\_\_  
Breast or bottle fed \_\_\_\_\_ Sat alone \_\_\_\_\_ mos. Walked \_\_\_\_\_ mos. Words \_\_\_\_\_ mos.  
Sentence \_\_\_\_\_ mos. First teeth \_\_\_\_\_ mos. Potty Trained? (age) \_\_\_\_\_  
How many ounces of milk does he/she drink in 24 hours? \_\_\_\_\_  
Has any one said he/she has a heart murmur? \_\_\_\_\_  
Is there a bedwetting problem? \_\_\_\_\_  
School performance: Scholastic \_\_\_\_\_ Conduct \_\_\_\_\_  
Has the child had a learning problem? \_\_\_\_\_  
Has he/she ever been in a special education class? \_\_\_\_\_  
Is your child taking any medication now? \_\_\_\_\_  
Does he/she have any handicaps? \_\_\_\_\_

## Past Illnesses

	Date		Date
Roseola	_____	Asthma	_____
Rubella (German Measles)	_____	Allergic to any med., food, insects	_____
Chicken pox	_____	Is he/she receiving allergy shots?	_____
Mumps	_____	<b>Operations</b>	
Ear infections	_____	Tonsils and Adenoids	_____
Tonsillitis	_____	Appendectomy	_____
Pneumonia	_____	Ear tubes	_____
Convulsions	_____	Other operations & hospitalizations	_____
Urinary infections	_____	Any other past illness	_____

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 for by your insurance.

**IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fee & cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions the patient's records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Pediatric Associates, P.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_