PEDIATRICS IN NORTH FLORIDA
RAPHAEL NG, M.D.

PATIENT INFORMATION (Please Print)

Child's Name _____ Date of Birth _____ Sex _____

Residence address _____ City _____ State _____ Zip _____

Home phone # _____ Email address _____

RESPONSIBLE PARTY INFORMATION

In our office the parent who requests treatment for the child is responsible for all fees. We do not bill the absent party unless they have made prior arrangements with our billing department. All private pay accounts are to be paid at the time of service.

Mother / Guardian name _____ Date of Birth _____ Driver License _____ Cell Phone # _____

Father / Guardian name _____ Date of Birth _____ Driver License _____ Cell Phone # _____

Mailing address _____ City _____ State _____ Zip _____

Emergency Contact (Other than parents) _____ Phone # _____

INSURANCE INFORMATION

Insurance Name _____ Policy # _____ Group # _____

Subscriber name _____ Date of Birth _____

I hereby authorize direct payment of surgical / medical benefits to Pediatrics in North Florida for services rendered in the office. I understand that I am financially responsible for any balance not covered by my insurance.

PARENT / GUARDIAN (Please print): _____

SIGNATURE: _____ **DATE:** _____

PEDIATRICS IN NORTH FLORIDA

PEDIATRIC - PATIENT QUESTIONNAIRE

Patient name: _____

Completed by: _____ Relation: _____

Please check [Y] yes or [N] no, circle or explain where required. N/A-Not Applicable

Reason for today's visit -

Previous medical care - Dr. Dental Care [Y] [N] Eye Exam [Y] [N]

PREGNANCY & BIRTH Mother's age at pregnancy? _____

Any illness during pregnancy? [Y] [N] _____

Medications during pregnancy? [Y] [N] _____

(exclude vitamins & iron) _____

Smoking - alcohol - street drugs - during pregnancy? _____

Was baby early - late - on time? _____

Type of delivery? _____ Birth weight _____ Length _____

Complications? [Y] [N] _____ Apgar _____

Problems with baby at birth? Breathing [Y] [N] Jaundice [Y] [N]

Other _____

Problems soon after? Nursery or home? _____

PAST MEDICAL HISTORY Allergic reactions? Medicine [Y] [N] Food [Y] [N] Animals [Y] [N]

Insect bites [Y] [N] _____

Medications taken on a regular basis? (exclude vitamins) _____

Immunizations - up to date? [Y] [N] Do you have a record? [Y] [N]

Hospitalizations - (when-where-why?) _____

Serious injuries (when-where?) _____

Red Measles	[Y] [N]	Mumps	[Y] [N]	German Measles (3 day)	[Y] [N]
Chicken Pox	[Y] [N]	Whooping Cough	[Y] [N]	Rheumatic Fever	[Y] [N]
Scarlet Fever	[Y] [N]	Ear Infections	[Y] [N]	Strep Throat	[Y] [N]
Asthma/Wheezing	[Y] [N]	Eczema/Hives	[Y] [N]	Seizures	[Y] [N]
Anemia	[Y] [N]	Hepatitis	[Y] [N]	Problems with hearing	[Y] [N]
Bleeding Tendency	[Y] [N]	Urinary Infections	[Y] [N]	Problems with vision	[Y] [N]
Blood Transfusions	[Y] [N]	Joint Problems	[Y] [N]	Other _____	

FEEDING & NUTRITION Food Allergies

Appetite usually good? [Y] [N]

Colic or feeding problems during the first 3 months? [Y] [N]

Breast fed? [Y] [N] Number of months? [Y] [N]

Formula? [Y] [N] Current brand? _____

Vitamins? [Y] [N] Brand? _____ Fluoride? [Y] [N]

Special Diet? [Y] [N] _____

FAMILY PROFILE Parents - Married? ☐ Separated? ☐ Divorced? ☐

Father's age? _____ Highest school grade? _____ Health? _____

Mother's age? _____ Highest school grade? _____ Health? _____

(List child's brothers, sisters & their ages)

_____

_____

_____

FAMILY MEDICAL HISTORY *List all blood relatives of your child who have had the following problems - use abbrev. (F) Father, (M) Mother, (B) Brother, (S) sister, (MM) Mother's Mother, (MF) Mother father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin*

Anemia/Blood Dis _____

Asthma _____

Mental Retardation _____

Drug Problem _____

Alcoholism _____

Cancer _____

AIDS _____

Cystic Fibrosis _____

Musc. Dystrophy _____

Tuberculosis _____

Arthritis _____

Epilepsy / Seizures _____

Heart Disease _____

High Blood Pressure _____

Cholesterol Problem _____

Migraine _____

Sudden Infant Death _____

Birth Defects _____

Early Deafness _____

Diabetes _____

DEVELOPMENT & BEHAVIOR *Age at which child -*

Sat alone ____ Walked ____ Used sentences ____

Toilet trained _____ Bicycled _____

Development compared to other children? _____

Grade in school ___ Problems in School? [Y] [N] ____

Learning problems? [Y] [N] _____

Getting along with other children? [Y] [N] _____

Behavior problems? [Y] [N] _____

Bad habits? _____ Bedwetting? [Y] [N]

Nail biting? [Y] [N] Sleeping? [Y] [N] Hobbies - sports -

Use of street or illegal drugs? [Y] [N] _____

SYNOPSIS

"PEDIATRICS IN NORTH FLORIDA"
Raphael Ng, M.D.

Privacy and Administration Practices

We are committed to provide you with the best possible care, and we will be pleased to discuss our Practice Policies with you at any time. Please ask us any question that you may have.

- All new patients will be asked to complete a "Patient Registration Form" prior to being seen by the doctor. We ask that you complete all the information.
- You have read and understood a copy of our Privacy Practices related to your child's medical information, as required by Federal Law.
- At least one parent or an authorized person must accompany the child/children seen in this office. The adult accompanying the child is responsible for any payments at the time of the visit.
- We schedule your child's appointments with the goal of a minimum waiting period. If you cannot keep your appointment and need to cancel or reschedule, please contact us 24 hours in advance, or as soon as you can prior to the appointment time. No-call/No-shows are recorded in the medical record, and the office will discharge your child/children from the practice after 2 No-call/No-shows.
- Please advise the office staff of any changes in your insurance policy, mailing address and phone number(s).
- If you are covered by any of our contracted plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit.
- The services ordered by our doctors to be performed outside of the office, i.e., laboratory work, radiology, therapy, etc. have to be filed or approved by the Insurance Company. It is the parent's responsibility to verify their policy coverage before performing non-emergency procedures to your children. The provider/Lab that performs a procedure will bill the parents for any payment. Pediatrics in North Florida is not responsible for the reimbursement of services not offered in our office.
- Initial request for Blue form, Yellow form and/or any College form, will be provided at no charge with annual wellness exam, a $25.00 fee will apply for a second request.
- There is a $25.00 charge for all medical forms / letter to be issued on behalf of the patient.
- Should it ever become necessary to use the services of a Collection Agency to collect on your account, you would be responsible for any costs incurred for that purpose.
- Payment arrangements can be requested with the Office Manager **PRIOR** to services being rendered.
- I request that payment of authorized insurance benefits be made on my behalf to Pediatrics in North Florida. I authorize any holder of my child's medical information to release to my health insurance company and its agents any information needed to determine benefits.
- I agree with the terms of the above-mentioned policies.

_____

Responsible Name (please print) Patient's Name (please print)

_____ _____

Responsible Party Signature Date