Alliance Pediatrics, P.A.
4627 NW 53rd Ave Gainesville FL 32653

Patient Demographic and Medical History Form

The following questionnaire will provide our staff information to best handle your individual billing, communication and health needs.

PATIENT INFORMATION

Patient: Last First Middle (Nickname)

BIRTH DATE Sex M ( ) F ( )

Child's Social Security # (must be registered for proper filing of insurance(s)

Address

City State Zip Code

Home Phone (including area code) Cell Phone

Race/Ethnicity
- ❑ American Indian/Alaskan ❑ Asian ❑ African American/Black
- ❑ Caucasian/White ❑ Hawaiian/Pacific Islander ❑ Other ❑ Decline

Primary Language____

Does this child live with: Father? ❑ Mother? ❑ Other Adult? ❑

GUARDIAN INFORMATION

Parent 1: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

Parent 2: Last First BIRTH DATE

Social Security Number

Address

City State Zip Code

Employer/Occupation Work Phone

EMERGENCY CONTACT INFORMATION

Nearest Relative: Last First Relationship

Phone Number (1) Phone Number (2)

PARTY RESPONSIBLE FOR BILLING

(Must be present at this appointment, provide picture ID card and sign bottom of this sheet)

Last First Middle Relationship to Patient
❑ Same as information listed under Guardian Info

BIRTH DATE Social Security #

Address

City State Zip Code

Home Phone (including area code) Cell Phone

Email:

INSURANCE INFORMATION

Subscriber Name L/F/M *(Primary Insurance Holder)* Relationship to Pt.
❑ Same as information listed under Guardian Info

BIRTH DATE Social Security #

Insurance Company Name Plan Type (PPO, HMO, Options, etc)

Subscriber ID # (Member ID) Group #

Insurance Company Address (Back of Card)

Insurance Company Phone Number (Back of Card)

Employer providing Insurance Phone

FAMILY INFORMATION

Brothers and Sisters DOB Health Issues?

____

____

____

____

PHARMACY INFORMATION

Pharmacy Name: Location

PRIOR CARE INFORMATION

What Doctor/Clinic has taken care of this child in the past? City Phone

It is the Guarantor's responsibility to know if Alliance Pediatrics participates in your insurance plan or network. Do this prior to seeing the Physician.

I hereby give annual authorization for payment of insurance benefits to be made directly to Alliance Pediatrics, PA for services rendered. I am financially responsible for all charges whether or not they are covered by insurance. I agree to pay all costs of collection and reasonable attorney's fees. I authorize the provider to release all information necessary to secure the payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original. I also consent to receive calls, texts and emails from Alliance Pediatrics for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Guarantor's Signature: ____ Date: ____________

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Medical Information and History Form

All responses are kept confidential

Today's Date: ____________________

____
Patient Name

____
Date of Birth **Time of Birth (Newborn)**

1. Were there any problems during the pregnancy or birth of this child?
❑ Yes ❑ No

____
If Yes, please explain

2. Has your child ever had any significant medical problems (including heart, liver, kidney problems, allergies, asthma, frequent infections, behavioral, growth, or developmental problems?
❑ Yes ❑ No

____
If Yes, please explain

3. Do any immediate family members have significant medical problems?
❑ Yes ❑ No

____
If Yes, please explain

4. Is there any family history of the following (please circle):
Heart disease before age 50, Diabetes, Cancer, Tuberculosis, Asthma, Allergies, Inherited Childhood Disease, Sickle Cell Anemia?

5. Does either parent have a total cholesterol over 240?
❑ Yes ❑ No

6. Any hospitalizations, accidents or surgery?
❑ Yes ❑ No

____
If Yes, please explain

7. Any medication allergies?
❑ Yes ❑ No

____
If Yes, list and describe

8. Any food or environmental allergies?
❑ Yes ❑ No

____
If Yes, list and describe

9. Are your child's immunizations up to date? (Please furnish records)
❑ Yes ❑ No

10. Does your child attend daycare? If so, where?
❑ Yes ❑ No

____
If Yes, please list

11. Does your child have any school or learning problems?
❑ Yes ❑ No

____
If Yes, please explain

12. Who lives in your home?

____

13. Are there any serious marital or family problems?
❑ Yes ❑ No

____
If Yes, please explain

14. Who smokes in the home? ____________________

Who has Legal Medical Decision-Making Rights for this child?

____
Name Relation to child

____
Name Relation to child

15. Do you feel safe at home? ❑ Yes ❑ No

16. Are there pets at home? ❑ Yes ❑ No

17. What is the child's primary source of water?
❑ City ❑ Well ❑ Bottle

18. Is the water fluorinated? ❑ Yes ❑ No

19. Does the entire family wear seat belts in the car?
❑ Yes ❑ No

20. Is the patient taking any OTC/Prescription Medications?

____

____

21. Is there any other information which would help us care for your child?

____

____

____

RISK SCREENINGS

Lead Exposure Risk:

Does your child live in or regularly visit a house built before 1960 with peeling/chipping paint or recent renovation?
❑ Yes ❑ No

Does your child have a sibling, housemate, or playmate with lead poisoning or a high lead level? ❑ Yes ❑ No

Is there an adult at home whose job or hobby involves lead exposure?
❑ Yes ❑ No

Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
❑ Yes ❑ No

TB(Tuberculosis) Risk Assessment:

Are you or the child foreign born?
❑ Yes ❑ No

Do you have a family history of TB? ❑ Yes ❑ No

Is there an adult with HIV infection in or around the family?
❑ Yes ❑ No

Do you have a family member who has been in jail within the past 5 to 10 years? ❑ Yes ❑ No

Do you have or care for foster children who may be at risk for TB or whose medical histories are missing?
❑ Yes ❑ No

Do you live in a high-risk neighborhood or in one with migrant families or homeless? ❑ Yes ❑ No

FOR OFFICE USE ONLY

____________________ ____________
Initials of Reviewing Provider Date