emerald coast PEDIATRICS

Date:_____ Email Address:_____ { } Send me emails

Name:_____ Date of Birth: _____ Age:_____ M { } F { }

Child SS#:_____ School:_____ Referred by:_____ Home PH#:(__)_____

Street Address:_____ City/State:_____ Zip:_____

Parent #1 Name:_____ M{ } F{ } Occupation/ Employer:_____ Work PH#:(__)_____ DOB:_____ SS#:_____

Mother's Name:_____ M{ } F{ } Occupation/ Employer:_____ Work PH#:(__)_____ DOB:_____ SS#:_____

Guardian (*if other than Parents*):_____ Occupation/ Employer:_____ Work PH#:(__)_____ DOB:_____ SS#:_____

Emergency Contact (*Other than parents*):_____ Address:_____ Phone#:(__)_____

Closest Relatives (*not at your address*):_____ Address:_____ Phone#:(__)_____

Insurance and Billing Information

Person Responsible:_____ Address:_____

Effective Date:_____ Billing Address:_____

Payment Required at the time of service – Unless prior arrangements have been made

1) Insurance Company:_____ Address:_____ Effective Date:_____

Subscriber's Name:_____ I.D.#:_____ Group#:_____

1) Insurance Company:_____ Address:_____ Effective Date:_____

Subscriber's Name:_____ I.D.#:_____ Group#:_____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Dr. Eehab A. Kenawy, M.D.for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization To Release Information

I hereby authorize Dr. Eehab A. Kenawy, M.D., to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Patient(please print):_____ Date:_____

Parent/Guardian (please print):_____ Signature:_____

Patient's Name:_____ DOB:_____ Reason for today's visit:_____

Please check {Y} yes or {N} no, explain where required.

Pregnancy/Birth: Mother's age at pregnancy:_____ Any illness during pregnancy? {Y} {N} Medications during pregnancy? {Y} {N}

Smoking/alcohol/street drugs during pregnancy? {Y} {N} Was baby early/late/on time? _____ Any complications?_____

Type of delivery?_____ Birth Weight:_____ Birth Length:_____ Problems soon after birth? Nursery or Home:_____

Past Medical History: Allergic reaction {Y} {N} Food {Y} {N} Animals {Y} {N} Insect Bites {Y} {N} Medicine:_____

Medication 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, why*):_____

Red Measles	{Y} {N}	Mumps	{Y} {N}	German Measles	{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}	Urinary Infections	{Y} {N}	**Problem With:**	{Y} {N}
Bleeding Tendency	{Y} {N}	Joint Injury	{Y} {N}	Hearing	{Y} {N}
Blood Transfusions	{Y} {N}	ADHD/ADD	{Y} {N}	Vision	{Y} {N}

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?_____

Formula? {Y} {N} Current brand:_____ Vitamins? {Y} {N} What brand?_____ Special diet? {Y} {N} Fluoride? {Y} {N}

Family Profile: (*Parent*s) Married { } Separated { } Divorced { }

Parent #1 Age:_____ M{ } F{ } Highest Level of Education Achieved?_____ Health?_____

Parent #2 Age:_____ M{ } F{ } Highest Level of Education Achieved?_____ Health?_____

List of Child's Brothers, Sisters, and their ages:_____

Family Medical History: List of all blood relatives of your child who have the following problems-use abbrav: {F} father, {M} mother, {B} brother, {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 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 Defect:_____
Early Deafness:_____ Diabetes:_____

Development & Behavior: Age at which child: Sat alone:_____ Walked:_____ Used Sentences:_____ Toilet trained:_____

Bicycled:_____ Grade in school:_____ Problems in school:_____

Learning Problems? {Y} {N} Getting along with other children? {Y} {N} Behavior problems? {Y} {N} Bad Habits? {Y} {N} Bedwetting? {Y} {N}

Nail biting? {Y} {N} Hobbies? {Y} {N} Sports? {Y} {N} Use of street or illegal drugs? {Y} {N}

Parent Signature:_____ Date:_____