Women's and Children's Physicians of Naples **Pediatric Patient Information Sheet**

Please Completely fill out all necessary information

Patient Information

Last Name **First Name** **Middle** **Preferred / Nickname**

Race **Primary Language** **Age** **DOB** **SEX** **M F** **SSN**

Address Information

Address **City / State / Zip** **County** **Country**

Phones:

Home **Work** **Mom Cell** **Dad Cell** **Primary**

Email **Birthplace / Hometown** **Ethnicity**

Parent's Information

Mother Name **DOB** **SSN** **Driver's License** Insurance Policy Holder **Yes NO**

Employer Name **FT/PT** **Occupation** **Phone / Ext.** **Hire Date**

Father's Name **DOB** **SSN** **Driver's License** Insurance Policy Holder **Yes NO**

Employer Name **FT/PT** **Occupation** **Phone / Ext.** **Hire Date**

Emergency Contact **Relation** **Phone**

Insurance Information:

Primary Insurance Carrier

Insurance Company **Policy Holder** **Policy Number** **Group Number**

I hereby authorize Women's and Children's Physicians of Naples to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount assigned to me by my insurance or any amount for services that are not covered benefits under my insurance plan.

Signature Date

AUTHORIZATION AND CONSENT TO OBTAIN MEDICAL INFORMATION FOR:

Women's and Children's Physicians of Naples
Louis F. Foley, M.D., F.A.C.O.G.
Jennifer M. Foley, M.D., F.A.A.P.
1217 Piper Boulevard, Suite 202
Naples, FL 34110
Telephone (239) 566-7272
Fax (239) 319-2001

TO: (physician or hospital)

_____

_____

_____

Patient Name: _____ Chart#: _____

Social Security #: _____ Birth date: _____

The information requested below will be used/disclosed for the following purposes: Ongoing medical care

I HEREBY REQUEST AND AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION: (PLEASE CHECK APPROPRIATE AREAS)

( )	History and Physical Exam	( )	Progress Notes
( )	Discharge Summary (Date: _____)	( )	Telephone Calls/Nurse & MD Notes
( )	Insurance Verification/Determination	( )	Laboratory Reports
( )	Significant Other Evaluation	( )	Report to Referral Source
( )	Psychiatric/Psychological Records	( )	Operative Report (Date: _____)
( )	Other (please specify): _____	( )	Correspondence (please specify): _____

I hereby authorize release of the above information, including psychiatric, alcohol, or other drug dependency history or treatment, and HIV/AIDS antibody testing results, to and/or from Women's and Children's Physicians of Naples, and hereby release the above from all legal liability that may arise from the release of the information requested. If, in the judgment of the medical staff, disclosure of certain information will be harmful if released to the patient, such information may be withheld in accordance with specific state and federal regulations.

This consent will also serve as authorization to disclose information to any person, corporation, or agency which is or may be liable for all or part of the physician charges or who may be responsible for determining the necessity, appropriateness, amount or other matter related to the treatment charges, including, but not limited to, insurance companies and/or third party reviewers. I further authorize disclosure of information to the program's insurance carrier when so requested by the carrier.

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above stated purpose, this consent will automatically expire one year from the date signed. I further understand that Women's and Children's Physicians of Naples reserves the right to notify the above named person, corporation, or agency of my revocation in the event that I revoke this consent to release information.

Patient/Parent/Guardian: _____ Date: _____

Please Print Name: _____ Date: _____

Women's and Children's Physicians of Naples

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Women's and Children's Physicians of Naples originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that service billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand, upon my request, I will be provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Women's and Children's Physicians of Naples is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Women's and Children's Physicians of Naples reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should Women's and Children's Physicians of Naples change their notice, they will send a copy of any revised notice to the address I've provided, (whether U.S. mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient Signature Date

Initial Medical Data for Newborns

Date _____ **Patient's Name** _____

Last First Middle

FAMILY MEMBER'S NAME	BIRTHDATE		STATE OF HEALTH

FAMILY ILLNESSES

Please mark an "X" in the boxes if your child's blood relatives have ever had any of the following illnesses. Some examples of illnesses are shown in the parenthesis ( ).

	Mother	Father	Sister	Brother	Other	Other
Allergies (medicines, foods, pollen)						
Birth Defects						
Blood Disease (hemophilia, anemia, leukemia)						
Bone or Joint Disorders						
Cancers or Malignancies						
Chronic Lung Disease(asthma, chronic bronchitis)						
Eye or Ear Disorders (glasses, etc.)						
Glandular Disease (diabetes, thyroid disease)						
Heart Trouble						
Kidney or Urinary disease						
Mental Retardation						
Muscle Disease (weakness, poor control)						
Nerve Disease (cerebral palsy, epilepsy)						
Psychiatric Condition						
Rheumatic Fever						
Tuberculosis (T.B.)						
Venereal Disease (Syphilis, Gonorrhea)						
Other						

MATERNAL AND FAMILY HISTORY

During pregnancy with this child, did you:

	Yes	No
Have high blood pressure?		
Have diabetes or sugar in your urine?		
Have albumin or protein in your urine?		
Have a urinary infection?		
Have German (3 day) Measles?		
Take medicines prescribed your doctor?		
Frequently smoke cigarettes?		
If **YES**, about how many packs per day?		packs
Have a venereal disease, such as		
Chlamydia, Gonorrhea or Syphilis?		
Have a dependency on drugs		
or alcoholic beverages?		
If yes, please explain:		
Other Conditions:		
How long was your pregnancy?		mo.
How early did you start seeing the doctor?		mo.
Was this child premature?		
Was there more than one baby born?		
Did you have a difficult delivery?		
Was it breech {bottom first} delivery?		
If yes, was it cesarean delivery?		
What was your child's weight at birth?	lb	oz
Was there an RH problem?		
Was anything wrong with your child at birth?		
If yes, What?		

MATERNAL AND FAMILY HISTORY

How many children have you (mother) had?..... _____
Which one is this child?..... _____
Have you (mother) had any premature births?..... _____
Have you (mother) had any cesarean births?..... _____
Have you (mother) had any miscarriages?..... _____

Mother's Age Now? _____ Mother's Height? _____

Father's Age Now? _____ Father's Height? _____

Number of people living in child's home? _____

Name of Place of Residence

Maternal Grandparents _____

Paternal Grandparents _____

Mother's Birthplace _____

Father's Birthplace _____

Mother's Occupation _____

Father's Occupation _____