



Is this your first visit at this office? Yes No Today's Date:

PATIENT INFORMATION

Name: Date of Birth: Sex: M F
Home Address: Your Preferred Language:
City: State: Zip:
Sibling Names and Ages (ex: Kelly, 12): Ethnicity:

PARENT/GUARDIAN INFORMATION

Primary Family Email:
Parent Name: Date of Birth:
Primary Phone: Alt Phone:
Employer: Work Phone:
Address (if different from child):
City: State: Zip:
Parent Name: Date of Birth:
Primary Phone: Alt Phone:
Employer: Work Phone:
Address (if different from child):
City: State: Zip:
Alternate Contact (relative or friend):
Alternate Contact Phone: ( )
Relationship to patient:

INSURANCE INFORMATION

Insurance Plan: Effective Date:
Name of Policy Holder: Date of Birth: Sex: M F

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Soni Family Practice, PLLC to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Soni Family Practice, PLLC. A photocopy of this authorization shall be considered as effective and valid as the original.

Billing Guarantor Name: (print)

Signature: Date:



Sex: M F Billing Guarantor Primary Phone#
Social Security #



## **AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Date: \_\_\_\_\_

Previous Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

I hereby authorize and request the complete Medical Record of the child(ren) listed above, be released to:

**SONI FAMILY PRACTICE, PLLC  
2217 NORTH BLVD. WEST- SUITE B  
DAVENPORT, FL 33837**

\_\_\_\_\_  
Signature of Parent / Legal Guardian

**SIGN HERE**

\_\_\_\_\_  
Date



Date: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PREVIOUS PHYSICIAN: \_\_\_\_\_

**PRENATAL HISTORY**

Were there any complications of the pregnancy? (such as diabetes, thyroid disease, toxemia, excessive bleeding) \_\_\_\_\_

Were there any complications of the labor or delivery? (such as prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breath) \_\_\_\_\_

Other relevant history?: \_\_\_\_\_

**ILLNESSES (Major illnesses such Asthma, ear infections, seizures, etc.)**

If yes, please explain: \_\_\_\_\_

Any "childhood" illnesses? (such as chickenpox, measles, etc.) \_\_\_\_\_ Yes \_\_\_\_\_ No

Fracture or other injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

**ANY PUBERTY ISSUES?:**

Any signs of breast development, adult body odor, voice change, adult hair patterns, periods? \_\_\_ Yes \_\_\_ No If yes, please explain:

**MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_

**DIET:**



Is there any particular MEDICAL condition that runs in your family? (such as , diabetes, hypertension, cardiovascular conditions, etc.) \_\_\_\_\_

Is there any particular GENETIC condition that runs in your family? (such as , Factor V Leiden deficiency, sickle cell disease, hemophilia, etc.) \_\_\_\_\_

**CHILD'S HISTORY**

**DEVELOPMENT:**

Please try to estimate the age at which your child could do the following things:

Sat alone: \_\_\_\_\_ Walked Alone \_\_\_\_\_ Spoke first word \_\_\_\_\_ Several words

**SCHOOL PERFORMANCE:**

Who lives at home? \_\_\_\_\_ Does mother work? \_\_\_\_\_

Preschool or Daycare? \_\_\_\_\_ Name preschool, childcare: \_\_\_\_\_

Who cares for child/children while parent(s) is/are at work? \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Has your child had any of the problems listed in the family history (separate page)? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Has she/he had frequent problems with:**

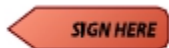
- Head: Headaches, dizziness, injury, other
- Eyes: Vision problems, infection, pain, other
- Ears: Hearing problems infections, pain, other
- Nose: Frequent stuffiness, easy bleeding, other
- Mouth: Tooth decay, poor bite, other
- Throat: Frequent sore throat, trouble with swallowing, other
- Neck: Stiffness, swelling, swollen glands, other
- Chest: Deformity, pneumonia, cough, asthma, other
- Heart: Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other;

- Abdomen: Vomiting, frequent pain, diarrhea, constipation, other
- Urinary: Pain on voiding, voiding frequently, bed wetting, other
- Skin: Rash, infection, other
- Neurological: Development problems, seizures, meningitis, other
- Endocrine: Weight gain or loss, intolerance to heat/cold, thirst, hair changes such as thinning or falling out, other
- Arms & Legs: Deformity, abnormal walking, joint pain, joint swelling, other
- Hematological: Anemia, abnormal bleeding, other: \_\_\_\_\_

If yes to any of the above, please explain: \_\_\_\_\_

**Are there specific problems you wish to discuss today?** If so, please explain: \_\_\_\_\_

Signature



Relationship to Patient

Date