SONI
FAMILY PRACTICE, PLLC

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:_____ SIGN HERE **Date:**_____

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

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Previous Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

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

_____ SIGN HERE _____
Signature of Parent / Legal Guardian Date

SONI
FAMILY PRACTICE, PLLC

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: _____

_____

_____ SIGN HERE _____ _____
Signature Relationship to Patient Date