PATIENT INFORMATION SHEET

PATIENT'S LAST NAME		FIRST	M.I.	SEX	ACCOUNT NO.
DATE OF BIRTH	SOCIAL SECURITY NUMBER	CHILD LIVES WITH (MOM, DAD)	NICKNAME (IF PREFERRED)		
LIST CHILD'S ALLERGIES		TYPE OF REACTION/FREQUENCY			
SIBLINGS NAME AND AGE			**CHILD'S BEST CONTACT PHONE #**		
CONTACT	EMERGENCY CONTACT INFO OR RELATIVE NOT LIVING IN HOUSEHOLD	RELATIONSHIP	EMERGENCY CONTACT PHONE		
	ADDRESS (STREET, CITY, STATE, ZIP)		EMERGENCY WORK PHONE		
MOTHER	MOTHER'S NAME (FIRST AND LAST)	DATE OF BIRTH	MOTHER SOCIAL SECURITY NUMBER		
	ADDRESS	CITY	STATE	ZIP	
	EMPLOYER NAME	EMPLOYER ADDRESS	BEST DAYTIME CONTACT PHONE #		
FATHER	FATHER'S NAME (FIRST AND LAST)	DATE OF BIRTH	FATHER SOCIAL SECURITY NUMBER		
	ADDRESS	CITY	STATE	ZIP	
	EMPLOYER NAME	EMPLOYER ADDRESS	BEST DAYTIME CONTACT PHONE #		
OTHER	NAME OF STEP PARENTS/OTHER	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
	ADDRESS	CITY	STATE	ZIP	
	EMPLOYER NAME	EMPLOYER ADDRESS	BEST DAYTIME CONTACT PHONE #		
PRIMARY INSURANCE	COMPANY NAME	POLICY NO.	GROUP NO.		
	INSURANCE COMPANY BILLING ADDRESS	CITY	STATE	ZIP	
	POLICY HOLDER'S NAME	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER'S SOCIAL SEC	
	POLICY HOLDER'S HOME ADDRESS	CITY	STATE	ZIP	
	POLICY HOLDER'S EMPLOYER	EMPLOYER PHONE	POLICY HOLDER PHONE		
	EMPLOYER ADDRESS	CITY	STATE	ZIP	
How did you hear about us?					

PLEASE READ AND SIGN BACK OF THIS FORM ⇨

INFORMATION ON APPOINTMENT SCHEDULING:

Our office requires a 2-week notice when calling to schedule a well checkup or physical. We generally schedule well baby visits at the time you check out from one well baby visit to the next. Example, you are here for a 2-month visit so the next well check up is in 2-months when the baby is 4-months so we will schedule the 4-month appointment while you are here. This allows you a better choice of times that will fit your schedule. EMERGENCY APPOINTMENTS are seen the same day you call. Example: High fever with vomiting, severe diarrhea, lethargic, asthma attacks, injuries, etc. SICK APPOINTMENTS are made within 24-48 hours. Example: sore throat, runny nose, cough, etc. If time is open we will give these symptoms a same day appointment. There are always exceptions and we try to accommodate all of our patients. PLEASE, if you wish to make an appointment for more than 1 child tell us when you call to schedule the appointment. This allows us to book the appropriate amount of time needed with the Doctor and ensure the chart is pulled. If you are more than 20 minutes late without notification to your appointment it may have to be rescheduled to another day.

FINANCIAL ARRANGEMENTS:

Payment is expected at the time of your child's appointment. This includes all Co-Payments. We accept CASH, CHECK, and CREDIT CARD. Returned checks will be billed a fee from our payment recovery provider. This fee can be in excess of $25. If other financial arrangements need to be made, they must be made when you schedule your child's appointment. Failure to cancel your child's appointment 24 hours prior to the scheduled appointment will result in a $5 fee charged to your account payable on or before your child's next appointment. FAILURE TO KEEP OR CANCEL UP TO THREE (3) APPOINTMENTS CAN RESULT IN THE RECORD RELEASE OF YOUR CHILD'S RECORDS. Failure to pay past balances due will result in account being sent to collections.

AUTHORIZATION AND RELEASE:

I **Authorize** Mid-Florida Pediatrics, PA (Dr. Virdi) to release any information, including the diagnosis and medical records of any treatment or examination rendered to my child during the period of such care, to my insurance company, including third party payers and/or other health practitioner or medical facility.

I **Authorize** my insurance company to review any/or all parts of my child's or children's medical records, for the sole purpose of quality assessment.

I **Understand** that my insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for payment of all services and/or ineligible charges on my behalf or my dependents.

I **Authorize** my insurance company or companies to make direct payment to Mid-Florida Pediatrics, PA (Dr. Manjit Virdi) for services rendered to my child or children while under the care of Dr. Virdi.

I **Authorize** Mid-Florida Pediatrics, PA (Dr. Virdi) and the health care staff to perform the necessary medical services my child/children may need.

Signature of Parent/Guardian	Print Name	Date

If you anticipate your child being brought to our office by someone other than the parent or legal guardian, or your teenager coming alone, this authorization for care must be signed and on file in order for us to treat the child when they come to our office for care, treatment, and/or immunizations.

Signature of Parent/Guardian	Print Name	Date

Child's Name _____