NEW PATIENT RECORD

NAME OF YOUR CHILD: _____ DATE: _____

Child's Medical History

Is your child having any medical problems? [ ] Yes [ ] No Is your child allergic to drugs? [ ] Yes [ ] No

FAMILY MEDICAL HISTORY:

Check if patient (**Pt**.) or a member of the patient's family (Parents (**P**), siblings (**S**), grandparents (**G**), aunts or uncles (**A** or **U**) have had the following illnesses or problems. *Please place the appropriate initial after each, if applicable*.

[ ] Allergies _____ [ ] Receives Allergy Shots _____

[ ] Drug Allergies _____ [ ] Asthma _____

[ ] Eczema _____ [ ] Frequent Respiratory Infections _____

[ ] Placement of Ear Tubes _____ [ ] Anemia or Blood Disorders _____

[ ] Stomach or Intestinal Problems _____ [ ] Diabetes _____

[ ] Growth Problems _____ [ ] Seizures or Convulsions _____

[ ] Cholesterol Problems _____ [ ] High Blood Pressure _____

[ ] Heart Attack or Stroke before age 55 _____ [ ] Cancer _____

[ ] Hereditary Problems _____ [ ] School Problems _____

[ ] Emotional or Behavioral Problems _____ [ ] Alcohol or Drug Problems _____

[ ] Did mother use tobacco, alcohol or other recreational drugs during pregnancy? _____

[ ] Other _____

_____

Maternal and Newborn History:

Pregnancy (*Check Problem Areas*)

[ ] Excessive Weight Gain [ ] Urinary Tract Infection [ ] Excessive Swelling
[ ] Rubella (3-day measles) [ ] Toxemia [ ] Venereal Disease
[ ] Other _____
_____

Birth Delivery: [ ] Vaginal [ ] Caesarean Section

Was baby: [ ] full term or [ ] pre-mature? Birth Wt. _____

Was labor difficult or prolonged? [ ] Yes [ ] No Was delivery difficult or complicated? [ ] Yes [ ] No

Newborn Feeding: [ ] Breast [ ] Formula _____

[ ] Feeding Problems [ ] Multiple Formula Changes [ ] Colic
[ ] Blood in stools [ ] Recurrent vomiting [ ] Slow weight gain
[ ] Recurrent diarrhea [ ] Jaundice [ ] Other

Signature: _____ Date: _____

Revised: 4/5/2017

MY CHILDREN'S DOCTOR
2484 CARING WAY STE F
PORT CHARLOTTE, FL 33952
TELEPHONE: (941) 625-1999

PATIENT NAME: _____ BIRTHDATE: ___/___/___ SOCIAL SECURITY_____-_____-_____

HOME PHONE: _____ MOTHER'S MAIDEN NAME: _____

CUSTODIAN: ____ MOTHER ____ FATHER ____ BOTH ____ GRANDPARENT ____ OTHER

MOTHER'S NAME: _____ D.O.B.: _____/_____/_____ SOCIAL SECURITY_____-_____-_____
(OR LEGAL GUARDIAN)
SIGNATURE_____ DRIVER'S LICENSE NO. _____-_____

FATHER'S NAME: _____ D.O.B.: _____/_____/_____ SOCIAL SECURITY_____-_____-_____
(OR LEGAL GUARDIAN)
SIGNATURE_____ DRIVER'S LICENSE NO. _____-_____

PRIMARY INSURANCE ID NO. _____ GROUP NO. _____

WHO PROVIDES THE PRIMARY HEALTH INSURANCE? ____ MOTHER ____ FATHER ____ OTHER

If other, give: Name of Policy Holder _____ D.O.B: ___/___/___ Soc. Sec._____-_____-_____

SECONDARY INSURANCE ID NO. _____ GROUP NO. _____

POLICY HOLDER: _____ D.O.B.: ___/___/___ SOCIAL SECURITY_____-_____-_____

ADDRESS WHERE THE CHILDREN LIVES MOST OF THE TIME:

_____

(NO. & STREET) (CITY) (STATE) (ZIP CODE)

MAILING ADDRESS: _____SAME AS ABOVE _____ DIFFERENT, SEE BELOW

MAIL TO:

_____

(NO. & STREET) (CITY) (STATE) (ZIP CODE)

All office visits MUST BE PAID AT THE TIME SERVICE IS RENDERED by the person bringing the child. This applies to divorced parents (including the parent without legal custody), babysitter, grandparents and other relatives who bring the child to the office for an exam.

OFFICE VISITS ARE MADE BY APPOINTMENT ONLY. In case of emergency call 911. After office hours, weekends and holidays, please go to the Emergency Room if you need urgent care or you may call the office number 625-1999 and the Answering Service will page Dr. Rodriguez or his coverage to call you back to answer your questions. If the doctor hasn't called you after 20 minutes, please call again.

I hereby authorize Dr. Rodriguez to release any information requested on the Insurance Claim Form, as well as payment to the Doctor for the services rendered. I understand that I am financially responsible for the charges not covered by the insurance.

Signature _____ Date: _____

Please present your insurance card to the receptionist. Also, please inform us in the future if your child's address, telephone number, or insurance changes.

Revised: 4/5/2017

My Children's Doctor, PA
2484 Caring Way Ste F
Port Charlotte, FL 33952
Phone: (941) 625-1999
Fax: (941) 625-4600

I, _____, authorize Dr. Luis R. Rodriguez to:

□ Send my medical records to: □ Obtain my medical records from:

Name: _____

Address: _____

Phone # / Fax #: _____

□ Medical records (except as authorized by law, release of HIV/AIDS or alcohol/drug related information will require a specific release form).

□ Medical records including HIV/AIDS, alcohol related information.

□ I am transferring to this doctor (free of charge).

□ I am not transferring care, but just want someone else to know about my care.

□ I am requesting these records to be released to myself. Upon receipt I release Dr. Luis Rodriguez of any or all legal responsibility from this date forward. (Release of these records will result in a charge of $1.00 per page).

This release applies to:

Name (please print)	**Birth Date**	**Relationship to Patient**

A photo static copy of this release is as valid as he original. I understand that I may withdraw consent at any time.

Name: _____

Signed: _____ **Date:** _____

Witness: _____ **Date:** _____

FOR OFFICE USE ONLY:

These records were mailed / faxed on _____ by _____

Revised: 4/5/2017