ORLANDO HEALTH Physicians
Summerport Family Medicine Group

Summerport Family Medicine
13528 Summerport Village Pkwy. | Windermere, FL 34786
p 407.614.8320 | f 407.614.8323

PEDIATRIC MEDICAL HISTORY

(Patients under age 18)

Patient Name: Last: _____ First: _____ MI: _____
Address: _____ City: _____ State: ___ Zip: _____
Sex: M F Date of Birth: _____ Age: _____

RESPONSIBLE PARTY: Parent or Guardian (circle one)
Last Name: _____ First: _____ MI: _____
Relationship to Patient: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Work Phone: _____ Cell phone: _____
Date of Birth _____ SSN ___-___-___ Age: _____
Employer _____ Work Phone _____
Spouse's Name _____
Spouse's Employer _____ Work Phone _____

INSURANCE INFORMATION - PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE
Policy Holder's Name _____ Relationship to Patient _____
Insured's SS # SSN _____-_____-_____ Insured's Date of Birth ___/___/_____
Secondary Insurance:
Policy Holder's Name _____ Relationship to Patient _____
Insured's SS # SSN _____-_____-_____ Insured's Date of Birth ___/___/_____

IN CASE OF EMERGENCY, NOTIFY
Name: _____ First: _____ MI: _____
Relationship to Patient: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Work Phone: _____ Cell phone: _____

METHOD OF PAYMENT CASH CHECK CREDIT CARD INSURANCE

How Did You Learn of our Office?_____

Birth _____ / _____ / _____ Age _____ School _____ Childs SS# _____ - _____ - _____

I consent to treatment and authorize the release of medical information necessary to obtain payment of medical benefits from my health insurance company and I authorize my insurance company to pay Summerport Family Medicine /West Orange Physician's Group, LLC any medical benefits due me for their services. I understand that I am responsible to pay deductibles, co-pays and any other charges not paid by my insurance company. Our policy is that payment is expected in full at time services are rendered, unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance company for the initial filing. You are responsible for repeat filings of insurance or filing to secondary insurance.

PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT. Therefore, verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary.
Should a minor child ever need medical attention and you are unavailable to give consent, this signed statement will serve as authorization for the physician to proceed with whatever medical care is necessary until you can be reached.
A copy of Summerport Family Medicine's Notice of Privacy Practices is available to me for review at my request. Copies are located in all exam rooms and the patient waiting rooms at each office.

NOTE whoever presents with the child for their doctors visit is responsible for payment.

Print Name: _____

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Patient Name: _____ Date of Birth: ____ / ____ / ____

1. **Pregnancy and Birth**: (fill out if child is under 6 years of age or if pertinent)
   a. Circle all problems during pregnancy:
   Rh Factor Anemia High Blood Pressure Toxemia Viral Illness Diabetes
   Other: _____
   Labor and Delivery: Normal Difficult C-Section Explain: _____
   Birth Weight: _____ Length: _____ Term, Pre-term or Post-term: _____

   Circle any complications of birth: Cyanosis (blue) Required Oxygen Jaundice
   Other Complications: _____
   Breast fed or bottle? _____ Any Unusual Feeding Problems: _____

2. **FAMILY HISTORY**: Circle if any family members (including grandparents, aunts, uncles) have any of the following:

Asthma	Bleeding Disorders	High Blood Pressure	Muscular Dystrophy
Alcohol Problems	Blood Vessel Disease	Heart Disease	Seizures
Allergies	Cancer	High Cholesterol	Strokes
Anemia	Cystic Fibrosis	Leukemia	Suicide/Depression
Arthritis	Diabetes	Mental Illness	Tuberculosis

   Other: _____

	Name	Age	Health Problems (Specify)
Father			
Mother			
Brother(s)			
Sister(s)			
Grandparent(s)			
Aunt/Uncle			

3. **MEDICAL ILLNESS**: Please circle if the child now has or has had in the past, any of the following:

Allergies	Broken Bones	Recurrent Tonsillitis
Anemia	Chicken Pox	Recurring Ear Infections
Asthma	Headaches	Rheumatic Fever
Bladder Infection	Heart Murmur/defects	Seizures

   Prior Surgeries: Appendectomy Tonsillectomy Tubes in ears Other: _____
   Hospitalizations: _____
4. **ALLERGIES**: Circle any allergies this child has:
   None Known Ceclor Penicillin Erythromycin Sulfa Other: _____
5. **MEDICATIONS**: List all medications child is taking, including Vitamins, Fluoride and Iron
   _____
   _____
6. **SOCIAL HISTORY**:
   Does child smoke? Y N If yes, how much? _____ Is child exposed to tobacco smoke? _____
   Who is the child's dentist? _____ Date of last visit ___ / ___ / ___
   List dental problems: _____
   Does child have any history of alcohol or drug abuse? _____
   Does child participate in sports? _____

PLEASE PROVIDE LIST OR COPY OF IMMUNIZATION RECORD