Lake Grove Pediatrics, P.C.

2233 Nesconset Hwy., Suite 207

Lake Grove, NY 11755

Lakegrovepediatrics.com

Phone: 631-585-4440

Fax: 631-585-4497

Name of Patient: _____

Address: _____

Home phone: _____ cell phone _____

Email:_____ SS# _____

DOB: _____ Patients sex: Male/Female

Guarantor's Name: _____

Guarantor's Address: _____

Guarantor's SS# _____ DOB:_____

Patient's mothers maden name: _____

Primary Insurance: _____

Name of policy holder: _____

DOB: _____SS#:_____

Insurance ID#:_____

Emergency contact: _____

I understand and agree that I am responsible for the balance on my account. I have completed this form to the best of my knowledge, and will notify you of any changes, should they occur. I hereby agree that in consideration of services rendered I shall be personally responsible for the payment of all charges not covered by my insurance carrier.

I understand that I will be personally responsible for deductibles, co-payments and billed charges, starting from the first office visit, if the bill is not paid in full.

****Please be advised:** failure to provide accurate insurance information with the proper insurance card(s) at the time of the visit may result in your claim being denied by your insurance carrier. **Any claim(s) denied resulting from inaccurate insurance information and/or insurance card(s) WILL BE THE GUARANTOR'S FINANCIAL RESPONSIBILITY.**

I authorize release of any information necessary to process the claims. I also authorize payments rendered directly to the provider.

Signed _____

Date_____

Lake Grove Pediatrics, P.C.

2233 Nesconset Hwy., Suite 207

Lake Grove, NY 11755

Lakegrovepediatrics.com

Phone: 631-585-4440

Fax: 631-585-4497

Your Childs Medical History

In order for us to know your child better, please answer all the following questions below.

Date: _____ Child's Name _____ D.O.B._____ Birth Wt _____

Yes No

____ ____ 1. Was your pregnancy less than 37 or more than 41 weeks? If so, how long was it? ___

____ ____ 2. Were there any problems with your pregnancy? (e.g. hospitalization, infection, early Labor) If yes, please explain _____

3. Was your delivery vaginal _____ Cesarian_____

____ ____ 4. Any problems with your delivery?

If yes, please explain_____

___ ____ 5. Did your baby have any problems in the nursery? (e.g. fever, breathing problems, Jaundice, NICU stay) if yes, please explain _____

_____

____ _____ 6. Has your child had any problems with growth or development? If yes, please explain

_____

____ _____ 7. Has your child ever been hospitalized overnight? If yes, please explain_____

_____

____ _____ 8. Has your child ever had any operations or surgery? If yes, please explain_____

_____

____ ____ 9. Has your child ever had any blood transfusions?

____ ____ 10. Has your child had any serious infections? (e.g. pneumonia, meningitis, UTI, MRSA, lyme Etc) If yes please explain _____

_____

____ ____11. Has your child had any other type of serious illness? (medical or traumatic) If yes please Explain _____

____ ____ 12. Does your child have any chronic illness? (e.g. asthma, heart problems, arthritis, sickle cell, seizures etc) If yes, please explain _____

_____

____ ____13. Does your child take medication for any problems? If yes, explain _____

_____

_____

____ ____14. Is your child allergic to any medication, foods, animals, latex or seasonal allergies? If yes, Please explain _____

_____

____ ____15. Has your child had any problems with any other the following: (if yes, please explain)

____ ____ Head, ears, eyes, nose, throat _____

____ ____ Heart _____

____ ____ Lungs_____

____ ____ stomach/bowel _____

____ ____ Kidney/bladder _____

____ ____ Muscles, nerves or brain _____

____ ____ Hip Disorders _____

____ ____ Excessive Bleeding _____

____ ____ Hearing/vision _____

____ ____ School Problems _____

____ ____ Emotional/Behavioral Problems _____

____ ____ 17. Does your child's mother, father or anyone in their immediate family have a history of:

____ ____ Genetic or Inherited illnesses _____

____ ____ Diabetes type I or II _____

____ ____ Asthma _____

____ ____ Hay fever/seasonal allergies _____

____ ____ Eczema _____

____ ____ Heart attack _____

____ ____ High blood pressure _____

____ ____ Heart Disease _____

____ ____ Seizures/epilepsy _____

____ ____ Cancer _____

____ ____ High Cholesterol _____

____ ____ Kidney Problems _____

____ ____ Alcoholism/substance abuse _____

____ ____ Psychiatric illness (bipolar, depression, schizophrenia)_____

____ ____ Any other serious illness _____

____ ____ 18. Does anyone living in your household smoke cigarettes?

____ ____ 19. Does anyone living in your household have a problem with alcohol or drugs?

____ ____ 20. Has your child had chicken pox disease? Date_____

21. What is the current marital status of the parents?

    Married _____ Single _____ Separated _____ Divorced_____

    Re-Married _____ Widowed _____

22. Who currently lives in your home? _____
    _____

23. Father's Occupation _____

24. Mother's Occupation _____

25. Please list names, birthdates and sex of siblings

Name DOB M/F

_____
_____
_____
_____
_____
_____

Please explain any other medical history that you consider important:

_____
_____
_____
_____
_____
_____

Reviewed by Lake Grove Pediatrics Provider:

Signature: _____ Date:_____