Today's Date:	**AZIZ IMTIAZ M.D.**

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	❑ Mr. ❑ Miss.	

Born in the USA? ❑ Yes	❑ No	Place of Birth:	Date of Birth: / /	Age:	Gender: ❑ M

Address:	Social Security Number:	Home Phone Number: ( )

P.O. box:	City:	State:	Zipcode:

Occupation:	Employer:	Employer Phone number: ( )

How did you hear about us?:

❑ Internet ❑ Family member ❑ Insurance ❑ Other

PARENT(S) INFORMATION

Parent's Name:	Date of Birth.: / /	Address (if different):	Home Phone Number: ( )

Ocupacion:	Employer:	Employer's Address:	Social Security Number:

Parent's Name:	Date of Birth: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Address of Employer:	Social Security Numberl:

INSURANCE INFORMATION

Primary Insurance:	Subscriber Name :	Member ID:

Name of secondary insurance (if applicable):	Subscriber Namer :	ID Number:

IN CASE OF AN EMERGENCY

Name of local friend or relative (no living with the patient) :	Relationship to the Patient:	Phone Number: ( )	Work Phone Number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that i am financial responsible for my balance. I also authorize PM PEDIATRICS, P.A or the insurance company to release any information required to process my claims

Patient/ Legal guarian of patient (if younger then 18 years of age)

Date

PM PEDIATRICS, P.A.

Web enabling will allow you to:

- Change and make appointments for your child.
- View immunizations given to your child at our office
- View the medical summary of all your child's visits at our office. (Diagnosis, Medication given, etc.)
- Receive educational articles on your child's diagnosis, medication or immunization
- And much more!

Ser Web enabled le permitirá:

- Cambiar y hacer citas para su niño/a
- Ver vacunas recibidas en nuestra oficina
- Ver el resumen médico de todas las visitas de su hijo/a (Diagnóstico, medicamento dado, etcétera)
- Recibir artículos educativos sobre el diagnóstico, medicamento, o vacunas de su hijo/a
- Y mucho más!

☐ Yes, I would like to be web enabled
Si, quiero estar web enabled
Email: _____@_____.com

☐ No, I would not like the feature at this time.
No, en este momento no quiero estar web enabled.

**Please keep in mind you can get this feature at anytime. **
**Tenga en mente que puede solicitar este programa a cualquier tiempo. **

Name:	□ M □ F	**D.O.B**
Previous Doctors Name:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY		
List any medical problems that other doctors have diagnosed		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	□ Yes	□ No

Please turn to next page

PM PEDIATRICS, P.A.

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	□ M □ F	
Mother				□ M □ F	
Sibling	□ M □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		**Grandmother** *Maternal*		
	□ M □ F		**Grandfather** *Maternal*		
	□ M □ F		**Grandmother** *Paternal*		
	□ M □ F		**Grandfather** *Paternal*		

CURRENT HEALTH PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

□ Skin	□ Chest/Heart	□ Recent changes in:

☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

I _____ am the parent/guardian of _____ DOB ___/___/_____ authorizes the following people to bring my child to the doctor's office in a case where I cannot:

Yo _____ el padre / guardián de _____Fecha de Nacimiento __ / __ / _____ autoriza a las siguientes personas para llevar a mi hijo a la consulta del médico en un caso en el que no puede:

Relationship to patient/Relacion al paciente:

1._____ _____

2._____ _____

3._____ _____

I am also aware that when the above listed bring my child to the doctor they also need to provide proper photo ID.

También soy consciente de que cuando el anteriormente enumerado llevar a mi hijo al médico también necesitan proveer identificación con foto apropiada.

Parent/guardian signature_____ Date: ___/___/_____

1412 W. Vine Street
Kissimmee Florida 34741
Phone: 407-483-0672 ° Fax: 407-348-5882

Financial Policy

Dr. Imtiaz and the staff of PM Pediatrics would like to welcome you to our practice. We strive to make you visit and convenient as possible, with our main goal being to provide your child with excellent medical care.

Please keep in mind that:

- It is your responsibility to inform our office of any demographic information changes (address, telephone, etc.)
- Your account is to be kept current, co-pay, self-pay, co-insurance, deductible charges will be collected at the time of service.(Services are payable by cash, credit or debit cards)
- If you do not have your payment(s) at check in, your appointment may be rescheduled.
- Any returned check will result in a $25.00 service charge and all future payments will be required in the form of cash or credit.
- There is a $30.00 charge for any outside paper work that is required to be filled out here and signed by the physician.
- All canceled appointments require a 24hour notice.
- All No show appointments are documented in your chart, after 3 “no show” appointments the privilege of same day appointments may not be available to you.
- If you have insurance coverage: we will submit your claims, however we must emphasize that as medical providers our relationship is with **you**, not your insurance company.
    - It is your responsibility to inform us of any insurance changes, so that the insurance can be verified prior to your visit.
    - You are responsible for any non-covered charges not payable by your insurance policy.

By signing below you confirm that you have read this policy and agree to what is stated above:

We realize that temporary financial problems may at times affect the timely payment of your account, if you ever have such a problem we strongly urge you to contact us to help you manage your account. If you have any questions about the information above please ask them. We are here to help you.

Patient name: _____ Signature of parent/patient (if 18yrs): _____ Date: _____

1412 W. vine Street

Kissimmee Fl 34741

Phone: (407)-483-0672 Fax: (407)-348-5882

Authorization to Release Medical Information

I hereby authorize the release of medical records, excluding protected record as follows:

Patient Name: _____ Date of birth: _____

- o All records
- o Immunization Records
- o Growth Charts
- o Laboratory testing
- o Radiology reports
- o Hospital documents
- o Chart Documents
- o Outside care information (if available)
- **o** Other:

_____

_____

Records to be released from:

Practice Name: _____

Phone Number :( ) - Fax Number: ( ) -

Address: _____

CITY: STATE: ZIP CODE:

Authorization given by:

Parent/ Guardian Name:_____ **Relationship to Patient**:_____

Signature: _____ **Date:** _____

This transmission contains confidential information some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability act (HIPPA) privacy rule. This transmission also may contain material protected by Federal privacy regulations or doctor-patient privileges. It is intended solely for the use of the addressee(s) named above, and may be privilege and confidential under the FL law. If you are not the intended recipient, any review, use, or distribution of this information is strictly prohibited. If you have received this confidential communication in error, notify the sender immediately by telephone and return the original of this transmission by U.S postal mail at the address shown above

Todas las preguntas contenidas en este cuestionario son estrictamente confidenciales
y pasará a formar parte de su expediente médico.