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

PATIENT INFORMATION

Last name:	First name	Middle	❑ Miss ❑Mrs.	❑ Mr.

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

Address:	Social Security Number:	Cellphone ( )

P.O. box:	City:	State:	Zip Code:

Occupation	Employer:	Employer No.: ( )

How did you find us?

❑ Internet ❑ Familiar ❑ Insurance plan ❑ Other

PARENT(S) INFORMATION

Mother Name	Date of birth.: / /	Address (if different):	Telephone No.: ( )

Occupation:	Employer:	Employer Address:	Social Security #:

Father Name	Date of birth: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer Address:	Social Security #:

INSURANCE INFORMATION

Primary Insurance Name:	Subscriber name:	ID #

Name of secondary insurance (if applicable):	Subscriber name:	ID #

IN CASE OF EMERGENCY

Name of friend/relative (who does not live at the same address):	Relationship to the patient:	Telephone number: ( )	Work Number ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the doctor. I understand that I am responsible for any balance not covered by my insurance. I also authorize [PM Pediatrics] or the insurance company to release all information necessary to process my claims.

Signature of patient/guardian

Date

Being Web enabled will allow you to:

- Change and make appointments for your child
- View vaccines received in our office
- View the medical summary of all your child's visits (Diagnosis, medication given, etc.)
- Receive educational articles about your child's diagnosis, medication, or vaccines
- And much more!

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

☐ No, at this time I do not want to be web-enabled.

****Keep in mind that you can apply for this program at any time. **

Name	☐ M ☐ F	**birthdate**
Previous doctor:	**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 received a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescription and over-the-counter medications, such as vitamins and inhalers		
Name the drug	MG	Frequency taken
Drug allergies		
Name the drug	Reaction:	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Brother	☐ 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

Please check if you have or have had any symptoms in the following areas to a significant degree and explain briefly

☐ Fur	☐ Chest/Heart	☐ Recent changes to:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Power level
☐ Nose	☐ Bladder	☐ ability to sleep
☐ Throat	☐ Intestine	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

I _____ the parent/guardian of _____Date of Birth ___ / ___ / _____ authorize the following people to take my child to the doctor's office in a case where he or she is unable to:

	Relationship with the patient
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

I am also aware that when the above listed take my child to the doctor I also need to provide appropriate photo identification.

Signature of Parent/Guardian_____ Date: ___/___/_____

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

Financial Policy

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

Please note that:

- It is your responsibility to inform our office of any changes in demographic information (address, phone, etc.)
- For any newborn that is **only** seen for a newborn visit, you will need to pay the **90-dollar** visit, unless the patient continues to be our patient for at least 6 months.
- Your account must be kept up to date; co-pay, self-pay, coinsurance, and deductible charges will be collected at the time of service (services are paid by cash, credit, or debit card).
- 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 cash or credit.
- There is a $30.00 charge for any outside paperwork that must be completed here and signed by the doctor.
- All canceled appointments require 24 hours' notice.
- All “no-show” appointments are documented in your file. After 3 “no-show” appointments, the same appointment privilege may not be available to you.
- If you have insurance coverage, we will file 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 changes to insurance so that insurance can be verified before your visit.
- You are responsible for any uncovered charges not paid by your insurance policy.

By signing below, you confirm that you have read this policy and agree to the above:

We know that temporary financial problems can sometimes affect the timely payment of your account. If you ever have such an issue, we strongly recommend that you contact us to help you manage your account. If you have any questions about the information above, please ask. We are here to help you.

Name of patient: _____ Parent/Patient Signature (if 18 years old): _____ Date: _____

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Kissimmee Fl 34741

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Medical Release Forms

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

Patient Name: _____ **Date of Birth:** _____

- All records
- Immunization records
- Growth Charts
- Lab test
- Radiology reports
- Hospital documents
- Graphic documents
- Outside care information (if available)
- Other:
- _____

_____

Records to be released from:

Office Name _____

Phone number:( ) _____ - _____ Fax number: ( ) _____ - _____

ADDRESS _____

CITY: _____ STATE: _____ ZIP CODE: _____

Authorization given by:

Name of Parent/Guardian:_____
Relationship with the patient:_____

Signature _____ **Date:** _____