Lane Pediatrics, PA
9260 Estero Park Commons Blvd.
Suite 100
Estero, FL 33928
P (239) 908-3593 F (239) 908-3597

PATIENT INFORMATION

Full Name ____ DOB ____________
First Middle Last

Home Address ____
Street Address Apartment/Unit #

____
City State Zip Code

Phone (_____)____________ ☐ Cell ☐ Home Email _____________________________

Primary Language(s) _________________________

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Sibling(s) and birthdate(s) ____

____

PREFERRED PHARMACY ____
Name Phone Number

PRIMARY INSURANCE

Insurance Company ______________________________

Name of Policy Holder _______________________________________ DOB ____________

Policy # _______________________ Group # _______________________

Person Responsible for Medical Bills (If Not Policy Holder) __________________________

PARENTS/LEGAL GUARDIANS

Mother's Name ____ DOB ___________
First Last

Home Address ____
Street Address Apartment/Unit #

____
City State Zip Code

Phone (_____)_____________ ☐ Cell ☐ Home Email ______________________

Father's Name ____ DOB___________
First Last

Home Address ____
Street Address Apartment/Unit #

____
City State Zip Code

Phone (_____)_____________ ☐ Cell ☐ Home Email ______________________

EMERGENCY CONTACT

Full Name ____
First Last

Phone (_____)_____________ ☐ Cell ☐ Home Relationship ______________________

I AUTHORIZE THE FOLLOWING ADULTS TO ACCOMPANY MY CHILD TO APPOINTMENTS AND MAKE NECESSARY MEDICAL DECISIONS:

____

____

I certify that the above information is accurate and true, to the best of my knowledge.

____ ______________________
Signature of Patient/Parent/Legal Guardian Date

FINANCIAL RESPONSIBILITY AGREEMENT

I, ________________________________, the guarantor, agree to be personally and fully responsible for the payment of any and all medical services, not covered by a federal, state or commercial benefit program, that are provided by Lane Pediatrics.

I understand that I am personally and fully responsible for the payment of all applicable co-payments, coinsurance, and deductible. I understand that all applicable payments are due at the time of services.

I understand that in the event that I am unable to pay for services, or in the event of an outstanding balance, I may be required to sign a payment agreement in order to remain a patient of Lane Pediatrics.

I authorize Lane Pediatrics and Financial Services of Southwest Florida to furnish information to all insurance carriers, including Medicaid, concerning the services I have received from Lane Pediatrics, and hereby assign to the physician all payment for medical services rendered to myself or my dependents for claims filed by this practice.

I acknowledge receipt and understanding of the written Financial Policies of Lane Pediatrics.

____ ____

Signature of Patient/Guarantor Date Witness Date

Patient Name ____

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:____ **DOB:** _____________
Last First Middle

AUTHORIZES:____
Name of Previous Pediatrician City, State

Phone: _________________________ Fax: _________________________

TO DISCLOSE TO:
Lane Pediatrics, PA
9260 Estero Park Commons Blvd.
Suite 100
Estero, FL 33928
P (239) 908-3593 F (239) 908-3597

DATE(S) OF INFORMATION TO BE DISCLOSED: From ______________ to ______________
Month/Year Month/Year

If left blank, only information from the past two (2) years will be disclosed.

INFORMATION TO BE DISCLOSED:
☐ All medical records related to (specify condition, treatment, etc): ____________________________________
☐ Radiology images/reports (specify test): ____
☐ Specific records/information as follows: ___Last WCC, most recent visit, immunization records, growth charts ____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:
☐Alcohol/drug abuse ☐ HIV test results ☐ Mental health

EXPIRATION: This authorization is good until the following date/event: ______________
If this item is left blank, the authorization will expire in one (1) year from the date signed.

PURPOSE: ☐Further medical care ☐ Personal records ☐ Other____________________________________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I agree to release the above named facility, it's affiliates, employees, and physicians from all legal responsibility and liability that may arise from the disclosure and/or unauthorized redisclosure of such information. I understand that I have a right to revoke this authorization at any time, and I must do so in writing. I understand that the revocation will not apply to the information which has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I understand that I do not need to sign this authorization in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: **DATE:**

____ _____________

Relationship: ________________________

Pediatric Health History Form

CHILD'S NAME: ______________________________ **DATE OF BIRTH:** ____________ **AGE:** _____

CHILD'S PREVIOUS DOCTOR/PCP: ____

BIRTH AND PREGNANCY

What city was your child born in? ____________________ Name of hospital: ______________________

Is this your child by: _____ Birth _____ Adoption _____ Step-child Other: _______________

Birth weight: ____________________ Was your baby premature? **Y / N**

Were there any significant medical problems during your pregnancy? **Y / N**

Were there any significant complications during labor or the baby's newborn period? **Y / N**

If yes to any of the above questions, please explain: ____

____

GROWTH AND DEVELOPMENT:

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc)? **Y / N**

If yes, please explain: ____

Girls only: Age at first period: _____

PAST MEDICAL HISTORY:

HAS YOUR CHILD:

Had any serious medical illness? **Y / N**

Had a history of asthma or wheezing? **Y / N**

Ever used an inhaler or nebulizer? **Y / N**

Had surgery? **Y / N**

Had any broken bones/frequent or severe sprains? **Y / N**

Had any mental or behavioral problems? **Y / N**

Had a positive tuberculosis skin test? **Y / N**

Been hospitalized overnight? **Y / N**

If yes to any of the above questions, please explain: ____

____

IMMUNIZATIONS: ***Please bring your child's immunization records to your appointment.***

Have you ever refused vaccines for your child? **Y / N**

If yes, why? ____

MEDICATIONS AND ALLERGIES

Please list current medications, vitamins, and supplements, even those used intermittently: ____________

____

Please list any allergies or reactions to medications, vaccines, or foods:

Allergy	Reaction
________________	______________________________
________________	______________________________
________________	______________________________

FAMILY HISTORY:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcohol/Substance Abuse												
Anemia												
Asthma												
Autism												
Autoimmune Disorder												
Birth Defect												
Bleeding Problem												
Cancer, Breast												
Cancer, ________												
Cancer, ________												
Depression												
Diabetes												
Eczema												
Food Allergy												
Genetic Disorder												
Hay Fever (Allergies)												
Hearing Disorder												
Heart Attack												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Mental Illness												
Mental Retardation												
Migraines												
Stroke												
Thyroid Disorder												
Other:												
Other:												

SOCIAL HISTORY:

Are your child's parents: _______ Married _______ Unmarried _______ Separated _______ Divorced

Child-care situation: _______ Parents _______ Others (specify who and hours per day) ____________________

Is violence at home a concern? **Y / N**

Are there pets in the home? **Y / N**

Are there guns in the home? **Y / N**

Do any family members smoke? **Y / N**