Patient Name: ________________________________ Date of Birth:______________ Sex: M F
Home Address:___________________________________ City:_____________________ State:______ Zip: __________
Your Preferred Language:_______________ Race:______________Ethnicity:______________ SS#:______-____-______
Sibling Names and Ages (ex: Kelly, 12)**:**____

PARENT/GUARDIAN INFORMATION

Primary Family Email:__________________________________
Parent Name:_____________________________________ Date of Birth:___________ SS#:______-____-______
Primary Phone:_________________________ **Alt Phone**: _____________________ Contact Preference____________
Employer:____ Work Phone: _____________
Address (if different from child):______________________________City:_________________ State:____ Zip: ________

Parent Name:_____________________________________ Date of Birth:___________ SS#:______-____-______
Primary Phone:_________________________ **Alt Phone**: _____________________
Employer:____ Work Phone: _____________
Address (if different from child):______________________________City:_________________ State:____ Zip: ________

Emergency Contact (relative or friend)Phone:_________________________ Relationship to Patient:________________

INSURANCE INFORMATION

Insurance Plan:_____________________________________Effective Date:__________________
Name of Policy Holder:____________________________Date of Birth:__________SS#:______-____-______Sex: M F

How did you hear about Soni Family Practice?_____________________________

Soni Family Practice offers a secure and convenient way to access your health care information such as updating your personal information, making appointments, viewing upcoming appointments, retrieving test results, etc. via the patient portal.

Yes No Would you like to have access to the patient portal?
(Please Circle One)

________ I consent to having my Immunization/Vaccination records retrieved.
(Please Initial)

________ I consent to having my medication history retrieved.
(Please Initial)

Insurance Payment Agreement & Authorization

I hereby authorize my insurance company to pay any benefits directly to Soni Family Practice, PLLC. I also understand and agree that any sum of money paid under this service shall be credited to my account and in the event the sum is insufficient to payout my account, I agree to be responsible for any non-covered services and balances not paid by my insurance within 30 (thirty) days. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Billing Guarantor Name:___________________________________ Billing Guarantor Primary Phone #:_____________________________ SS#:______-_____-_____

Signature: ____ Date:__________________________

Release of Information

I request and authorize Dr. Soni of Soni Family Practice, PLLC to obtain any necessary medical records from the hospital, physician's office, laboratory, or diagnostic centers. I understand that my records have a privileged and confidential status. I am waiving that status and authorizing the release of information regarding clinical information.
Signature: ____ Date:__________________________

Receipt of Notice of Privacy Practice Acknowledgement Form

I, ____, have received and reviewed a copy of Soni Family Practice, PLLC's Notice of Privacy Practices.

DATE OF BIRTH: ________________________________ SEX: _________________________

REFERRED BY: ________________________ PREVIOUS PHYSICIAN: __________________

PRENATAL HISTORY

Were there any complications of the pregnancy? (such as diabetes, thyroid disease, toxemia, excessive bleeding) ____

____

Were there any complications of the labor or delivery? (such as prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breath) _________________________

____

Other relevant history?: ____

ILLNESSES (Major illnesses such Asthma, ear infections, seizures, etc.)
If yes, please explain: ____

____

Any "childhood" illnesses? (such as chickenpox, measles, etc.) ________ Yes ________ No
Fracture or other injury? ________ Yes ________ No
If yes, please explain:

____

____

ANY PUBERTY ISSUES?:
Any signs of breast development, adult body odor, voice change, adult hair patterns, periods? ___Yes ___No If yes, please explain:

____

____

MEDICATIONS:

____________________ ______________________ ______________________

____________________ ______________________ ______________________

ALLERGIES: ____

DIET: ____

2217 North Blvd West – Suite B, Davenport, FL 33837 ♦ Phone: (863) 588-4775 ♦ Fax: (863) 422-7664
www.SoniFamilyPractice.com

Is there any particular GENETIC condition that runs in your family? (such as , Factor V Leiden deficiency, sickle cell disease, hemophilia, etc.) ____

____

CHILD'S HISTORY

DEVELOPMENT:
Please try to estimate the age at which your child could do the following things:
Sat alone: _________ Walked Alone _________ Spoke first word _________ Several words

SCHOOL PERFORMANCE:
Who lives at home? ___________________________________ Does mother work?
Preschool or Daycare? ____________________ Name preschool, childcare:
Who cares for child/children while parent(s) is/are at work?

REVIEW OF SYSTEMS:
Has your child had any of the problems listed in the family history (separate page)? _____ Yes _____ No
Has she/he had frequent problems with:

_____ Head: Headaches, dizziness, injury, other
_____ Eyes: Vision problems, infection, pain, other
_____ Ears: Hearing problems infections, pain, other
_____ Nose: Frequent stuffiness, easy bleeding, other
_____ Mouth: Tooth decay, poor bite, other
_____ Throat: Frequent sore throat, trouble with swallowing, other
_____ Neck: Stiffness, swelling, swollen glands, other
_____ Chest: Deformity, pneumonia, cough, asthma, other
_____ Heart: Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other; ____
_____ Abdomen: Vomiting, frequent pain, diarrhea, constipation, other
_____ Urinary: Pain on voiding, voiding frequently, bed wetting, other
_____ Skin: Rash, infection, other ____
_____ Neurological: Development problems, seizures, meningitis, other
_____ Endocrine: Weight gain or loss, intolerance to heat/cold, thirst, hair changes such as thinning or falling out, other ________________________________
_____ Arms & Legs: Deformity, abnormal walking, joint pain, joint swelling, other
_____ Hematological: Anemia, abnormal bleeding, other: ___________________________

If yes to any of the above, please explain:
Are there specific problems you wish to discuss today? If so, please explain: ___________________

____

______________________ SIGN HERE ______________________ __________
Signature Relationship to Patient Date