Internal Medicine & Pediatric Associates
6919 Old Canton Road
Ridgeland, MS 39157
Phone: (601) 956-0911
Fax: 601) 952-0474

Date:_____

PATIENT INFORMATION SHEET

LAST NAME _____ FIRST_____ MI _____

ADDRESS_____ APT_____

CITY _____ STATE_____ ZIP_____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

PATIENT'S DATE OF BIRTH _____/_____/_____ PATIENT'S SEX _____M _____F

MARITAL STATUS ____SINGLE ____MARRIED ____DIVORCED ____WIDOWED ____SEPARATED ____PARTNERED

PATIENT'S SOCIAL SECURITY NUMBER _____-_____-_____

RESPONSIBLE PARTY IS AUTOMATICALLY THE PATIENT UNLESS THE PATIENT IS A MINOR.

IF MINOR, PARENTS INFORMATION

FATHER'S NAME_____ DOB _____/_____/_____

EMPLOYER _____ PHONE _____

CELL PHONE (_____)_____ SOCIAL SECURITY _____-_____-_____

MOTHER'S NAME_____ DOB _____/_____/_____

EMPLOYER _____ PHONE _____

CELL PHONE (_____)_____ SOCIAL SECURITY _____-_____-_____

EMPLOYER INFORMATION

EMPLOYER NAME_____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

EMPLOYER PHONE (_____) _____ EXT_____

EMPLOYMENT STATUS _____F/T _____P/T _____NA STUDENT STATUS _____F/T ____P/T

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

HOME PHONE _____ WORK PHONE _____

MESSAGES

OK TO LEAVE MESSAGES AT HOME _____YES _____NO

AT WORK _____YES _____NO

If you would like to be contacted through email for clinic events, such as Flu Shot Clinic, Easter Hunt and Fall Festival, please provide us with your email address:_____

AUTHORIZATION TO RELEASE INFORMATION TO

If left blank, your medical information will not be released to anyone.

NAME_____RELATIONSHIP_____

HOME PHONE (_____)_____ CELL PHONE (_____)_____

PHARMACY

NAME _____ LOCATION_____

PHONE (_____)_____ FAX (_____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

POLICY HOLDER NAME _____ RELATIONSHIP_____

POLICY HOLDER DOB _____/_____/_____ POLICY HOLDER SOCIAL SECURITY_____-_____-_____

ID# _____ GROUP # _____

SECONDARY INSURANCE _____

POLICY HOLDER NAME _____ RELATIONSHIP_____

POLICY HOLDER DOB _____/_____/_____ POLICY HOLDER SOCIAL SECURITY_____-_____-_____

ID# _____ GROUP # _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

We sincerely appreciate the opportunity to serve the medical needs of you and your family. Please take a moment and tell us how you heard about us.

_____Friend Name_____

_____Relative Name_____

_____Physician Name_____

__Kid's Directory__Parent & Child Magazine ___Mail Out____Billboard ____Dropped by on my own

AUTHORIZATION FOR TREATMENT AND PAYMENT AGREEMENT

- I authorize the use of this form and information on all my insurances submissions.
- I authorize the release of information to my insurance company.
- I authorize payment to be made directly to Internal and Pediatric Associates, PLLC.
- I authorize Internal Medicine and Pediatric Associates to act as my agent in helping me to obtain payment from my insurance company.
- I understand I am responsible for my bill.
- I understand I am responsible for my co-payment, co-insurance, and deductible at the time services are rendered.
- I authorize Internal Medicine and Pediatric Associates, physicians and staff, to render treatment to myself or child.

Patient Name (please print) _____

Signature of Patient or Guardian _____

Date _____/_____/_____

Internal Medicine and Pediatric Associates

2011 Patient Financial Policy

Patient Name: _____ **Date:** _____

You are responsible for the payment of co-payment, co-insurance, deductibles, non-covered services, or any patient responsibility at the time services are rendered. If you are covered by a plan in which we participate as a provider, we will file your insurance claim. In the event that your insurance carrier does not pay the balance we will notify you so that you may contact your insurance carrier or resolve your account. In the event that your coverage has changed, lapsed, or expired on the date services are rendered, all charges will be denied and become the patient's responsibility.

Co-payments, Co-insurance, and Deductibles: Insurance contracts obligate patients to pay their patient portions and providers to collect these amounts. Please be prepared to pay your co-pay, co-insurance, non-covered services, and deductible amounts at the time services are rendered.

Out of Network Plans: Payment is due in full at the time services are rendered. As a courtesy, we will file a claim to your insurance carrier on your behalf or provide you with a claim form for filing.

Self Pay Patients: Payment is due at the time services are rendered.

Secondary Insurance Carriers: We will file secondary claims if we are participating with the insurance carrier network. If we are non-participating, we will provide the patient with a claim form. If your insurance carrier does not process the claim within 45 days of the claim being filed, the balance becomes the patient's responsibility.

Please read and initial each blank.

_____ Patient agrees to pay for all portions of services due in full at the time services are provided by our office.

_____ Patient must advise the front office personnel of any insurance changes in a timely manner.

_____ If account balances are not paid according to terms, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, the patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

_____ I understand that IMPA accepts cash, Visa, and MasterCard as payment.

_____ If payment of charges imposes a financial burden, payment arrangements must be negotiated **prior** to services being rendered. And are at the discretion of the billing department and the physician providing services.

_____ I have read the cancellation policy. I understand that a cancellation fee will be charged if I do not cancel or reschedule within 24 hours of the scheduled appointment time unless there is a valid reason for the cancellation. This will be determined at the discretion of the Office Manager.

_____ Until my account is settled, I give my consent to receive communications including voice messages regarding my account through various means such as: cell, landline number or email address that I have provided.

Patient/Guarantor Signature: _____**Print Name:** _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____Birthdate_____

Signature_____

Date_____

INTERNAL MEDICINE AND PEDIATRIC ASSOCIATES OF RIDGELAND, PLLC
PEDIATRIC HEALTH HISTORY FORM FOR NEW PATIENTS

Child's Name First:	Middle Initial:	Last:	Date
Child's Previous doctor/ Primary Care Provider	DOB		Age
Allergies/Reactions:			

PRESENT HEALTH CONCERNS	**MEDICATIONS/VITAMINS**	**HERBS/HOME REMEDIES**

PREGNANCY AND BIRTH

1.	Is this child your by: ☐Birth ☐Adoption ☐Stepchild ☐Other:
2.	Please indicate any medical problems during pregnancy: ☐None ☐Specify:
3.	Delivered by: ☐Vaginal Birth ☐Caesarean If caesarean, why:
4.	Birth Weight: Birth Length:
5.	Please indicate any medical problems during the baby's birth: If premature, how early?

Other problems that developed after birth and within the first year of life:

_____

_____

NUTRITION AND FEEDING

1.	Was your child breastfed? ☐No ☐Yes If so, how long?
2.	Has your child had any unusual feeding/dietary problems? ☐No ☐Yes If yes, specify:
3.	Milk intake now: Type ☐Cow milk (☐non-fat ☐1% fat ☐2% fat ☐whole milk) ☐Soy milk ☐Formula Formula Brand and Type:

Average ounces per day (Note: 8 ounces are in 1 cup):

SLEEP

Hours per night: Naps (number and length):

Any sleep problems: ☐No ☐Yes, explain:

DEVELOPMENT

Are there developmental concerns for the child? ☐·No ☐·Yes, If so, what are they?
Has the child been involved in any early development therapy? ☐No ☐Yes, If so, where?

Girls only: Age at first menstrual period:

DENTAL HISTORY

Has child been seen by a dentist? ☐No ☐Yes If so, how often: Date of last visit:

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.

Has your child had chickenpox ☐No ☐Yes
Is your child behind on any immunizations? ☐No ☐Yes, If so, which ones?

EXPOSURES/HABITS:	Any concerns about lead exposure (old home/plumbing/peeling paint)? ☐No ☐Yes
_____ _____ _____	

Do any household members smoke? ☐No ☐Yes
TV hours per day: Computer hours per day: Video games hours per day:

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates:

_____

_____

_____

ADDITIONAL HISTORY: HOSPITALIZATIONS/OPERATIONS/BROKEN BONES/SEVERE SPRAINS (WITH DATES)

_____

_____

_____

_____

SOCIAL HISTORY	Birthplace:		Current (or upcoming) grade:
Who lives at home:			
Name:	Age:	Sex:	Relationship:
Name:	Age:	Sex:	Relationship:
Name:	Age:	Sex:	Relationship:
Name:	Age:	Sex:	Relationship:
Name:	Age:	Sex:	Relationship:
Are the child's parents: ☐Married ☐Unmarried ☐Separated ☐Divorced If divorced, when?			
Parent's Occupation: Mother:		Father:	
Child care situation ☐Parents ☐Other (specify who and hours per day):			
Concerns about your child: ☐Alcohol use/Tobacco ☐Depression ☐Sexual activity ☐Aggressive behavior ☐ADD/ADHD			
Is violence at home a concern: ☐No ☐Yes	Is child seeing a psychiatrist? ☐No ☐Yes, if so, who:		
SCHOOL HISTORY	Did/does your child attend school? ☐No ☐Yes Current Grade:		
Name of school**:**	Any concerns about school performance?		
Any concerns about relationships with: Teachers ☐No ☐Yes, explain: Students ☐No ☐Yes, explain:			
Does child participate in sports/exercise: ☐No ☐Yes Type:	How often?		

REVIEW OF ORGAN SYSTEMS: IF CHILD HAS MORE THAN ONE SYMPTOM IN A LINE, CIRCLE THE RELEVANT ONE(S).

Constitutional/Endocrine ☐Fevers/chills/excessive sweating ☐Unexplained weight loss/gain ☐Fatigue/lethargic	**Gastrointestinal** ☐Nausea/vomiting/diarrhea ☐Constipation ☐Blood in bowel movement ☐Abdominal pain ☐Reflux	**Allergy** ☐Hayfever/itchy eyes **Respiratory** ☐Cough/wheeze ☐Asthma
Eyes ☐Squinting/"crossed"eyes/ asymmetric gaze	**Cardiovascular** ☐Tires easily with exertion ☐Shortness of breath ☐Fainting ☐Chest tightness	**Skin** ☐Rashes ☐Unusual moles ☐Eczema
Ears/Nose/Throat ☐Talks loud /hard of hearing ☐Ear pain ☐Throat pain ☐Mouth breathing/snoring ☐Bad breath ☐Frequent runny nose	**Genitourinary** ☐Bedwetting/frequent accidents ☐Pain with urination ☐Discharge: penis or vagina ☐Frequent urinary tract infections	**Psychiatric** ☐Anxiety/Stress/Depression ☐Problems with sleep/nightmares ☐Nail biting/thumbsucking ☐Bad temper/breath holding/jealousy ☐Attention Deficit /Hyperactivity
Muscular ☐Muscle/joint pain	**Neurological** ☐Headaches ☐Weakness ☐Seizures	**Blood/Lymph** ☐Unexplained lumps ☐Easy bruising/bleeding

PERSONAL MEDICAL HISTORY OF THE CHILD:
Is the child adopted? □ No □ Yes If yes, and you do not know the family history skip this section and continue to **Other Health Issues**.
Is the mother living? □ No □ Yes If yes, is she in good health? □ No □ Yes If no, age and cause of death:_____
Is the father living? □ No □ Yes If yes, is he in good health? □ No □ Yes If no, age and cause of death:_____

FAMILY HISTORY OF THE CHILD: Indicate which relative has had the following diseases (parents and siblings are most important). Please indicate maternal or paternal grandparents.

Any Genetic Disease:
Alcoholism/Drug Abuse:
Asthma, Hay Fever:
Birth Defects:
Cancer-type:
Diabetes:
Heart Disease, Stroke:
High Blood Pressure:
High Cholesterol:
Kidney Disease:
Tuberculosis:
Other:

By signing below, I attest that I have answered the questions on this health history form truthfully and to the best of my abilities.

_____
Print Patient Name

_____
Print Parent/Guardian Name
If you are not the parent or guardian of the child, what is your relation to the child?_____
Has permission been obtained for this child to be seen at our clinic?_____

_____ _____
Parent/Guardian Signature Date

Thank-you for taking the time to fill this extensive health history from out, it will greatly benefit the provider in taking care of your child. Please be aware that if your child's medical record needs to be forwarded to a specialist that we have referred them to, this health history form will be included in your child's records that are sent.