MY FIRST DOCTOR

ELIZABETH ANNE SMITH, M.D.

13043 Summerfield Square Dr. Riverview, FL 33578

Office: 813.418.7282/ Fax: 813.677.7141

PATIENT DEMOGRAPHIC INFORMATION

Child's last name_____,First_____

Date of Birth_____Male____Female____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name_____

Address_____

City_____State_____Zip Code_____

Home Phone (_____)_____Cell(_____)_____

Work(_____)_____ext_____May we contact you here? **Yes** **No**

Place of Employment_____

Driver's License State_____Number_____

Relationship to Patient_____

Email Address_____

INSURANCE INFORMATION

Primary Insurance
Company_____

Insurance
ID#_____Group#_____

Medicaid Insurance? Yes No

I understand that I am responsible for all charges incurred whether or not paid by my insurance company. I hereby authorize this office to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed. I hereby authorize and direct all payments, otherwise payable to me under the terms of my insurance, to Elizabeth A. Smith, M.D. for the medical and/or surgical benefits, if any. I understand that there is a $25 fee for any check returned by the bank for any reason whatsoever. If my check is returned for non-sufficient funds, I expressly authorize my account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. Furthermore, I understand that if a check is returned for any reason whatsoever, Elizabeth A. Smith, M.D. may refuse payment in the form of a check in the future. The use of a check for payment is my acknowledgement and acceptance of this policy and its terms and conditions. I understand that I am responsible for scheduling of appointments for my medical care. I further understand that if I fail to keep an appointment or cancel the appointment with less than 24 hours notice that I will be charged a "no-show" fee that is NOT reimbursable by my insurance company. I agree and understand that I may be charged 1.5% interest rate per month on any unpaid balance. I am responsible for any costs incurred in collection of said balance should that become necessary. All payments are due at the time services are rendered.

I have read and understand the above statements.

_____

Signature of Responsible Party **Date**

*****COPY OF INSURANCE CARD AND PHOTO ID REQUIRED**

Office Policies

It is our policy that office visits be paid in full at the time of visit.

I fully understand that if my account should need to be turned over to a collection agency for non-payment, that I will be charged an additional percentage of the amount to cover the agency's fees.

No Show Appointment Policy

I fully understand that 24 hours' notice is required to avoid a no show fee. My First Doctor has the right to charge a no show fee for missed appointments and I understand that my child may be discharged from the practice at the doctor's discretion due to chronic no show appointments.

Permission for Treatment

Permission is hereby granted for physicians, employees, or agents of MY FIRST DOCTOR to render the patient named below such medical and surgical treatment as deemed necessary.

Permission to Release Medical Information

I authorize MY FIRST DOCTOR to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-payers or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. **This authorization is valid for every visit to MY FIRST DOCTOR until written notice revoking it is provided.**

I release MY FIRST DOCTOR of all responsibility for loss of confidentiality through access and/or copies made of records released in compliance to this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payment, release of information, and permission for treatment.

Patient's name

_____

Patient or Legal Guardian's Signature

_____

If Legal Guardian, Relationship to Patient

_____ **Date** _____

MY FIRST DOCTOR

Oral Lead Risk Assessment Questions

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

1. Since the last oral risk assessment have there been any significant changes in day care, your home, hobbies, or occupation? (If no, using the medical provider's professional judgment, only pertinent questions to assess current risk should be asked such as #7) **YES NO**

2. Has the mother of the infant worked or lived where she has been exposed to lead? **YES NO**

3. Does your child live or frequently (once a week or more) visit a house built before 1960? Was your child's day care center/preschool/babysitter's home built before 1960? Does the house have peeling or chipping paint inside or outside? Is there old furniture or painted woodwork that your child can chew on? (ex. Crib, banister) Does your child exhibit pica? **YES NO**

4. Does your child live in a house built before 1980 with recent, ongoing, or planned renovation or remodeling? **YES NO**

5. Does your child live or frequently visit a home near heavily traveled major highway where soil and dust may be contaminated with lead? Is your child's daycare near a busy roadway? **YES NO**

6. Does your child regularly eat from ceramic or pewter dishes? Is food stored in cans, ceramic ware, or pottery? **YES NO**

7. Have any of your children or their playmates had lead poisoning? **YES NO**

8. Based on the occupations of all household members and frequent visitors, does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery, or other trades in the community. Does anyone in the household have a hobby which uses lead? Examples are fishing weights, casting ammunition, toy soldiers, making stained glass, making pottery, refinishing furniture, burning lead painted wood. **YES NO**

9. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? Does your child live near a source of current industrial pollution or on the site of the old industry of mining? **YES NO**

10. Do you give your child any home or folk remedies, which may contain lead? Examples would be: Alarcon, Alkohl, Azarcon, Bali Goli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, and Rueda. **YES NO**

11. Does your home's plumbing have lead pipes or copper with lead soldier joints? Have there been any plumbing repairs or fixtures added within the last 5 years? **YES NO**

PERMISSION TO TREAT/PRIVACY CONSENT

I(We) authorize the following people to bring my child in for treatment:

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

May we leave messages regarding your child on voicemail/answering machine? YES NO

May we contact you by email regarding information about your child (if applicable)? YES NO

_____

Sinature of Parent/Guardian Date

Relationship to Patient_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date_____

Previous Physician_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Child/Patient Name_____

Date of Birth_____

I hereby authorize and request the complete Medical Record of the child listed above to be released to:

My First Doctor
Elizabeth Ann Smith, M.D.
13043 Summerfield Square Dr.
Riverview, FL 33578
Fax # 813.677.7141

_____

Signature of Parent/Guardian Date

Relationship to Patient_____