South Plains Pediatric Cardiology, P.A.

Patient Information

Patient Name:_____Age:_____DOB___ /___ /_____Sex: M / F

Social Security _____-_____-_____ Referring Pediatrician:_____

Patient's Guardian Information

Name*:* _____DOB ___ /___ /_____Relationship_____

Address: _____ City:_____ State:____Zip:_____

Phone Number: (____)____-_____ Cell / Home/ work Social Security _____-_____-_____

Name: _____DOB ___ /___ /_____Relationship_____

Address: _____ City:_____ State:____Zip:_____

Phone Number: (____)____-_____ Cell / Home/ work Social Security _____-_____-_____

Who else can bring patient to medical appointments?_____

_____

Insurance Information: If you have more than one insurance you **must** provide both at the time of visit.

Commercial/Other:_____

Policy holder/Subscriber:_____

DOB:_____**Address:**_____

TX Medicaid(please circle which applies): Traditional medicaid Firstcare Superior Amerigroup

CHIP(please circle which applies): Firstcare Superior Molina of TX

NM Medicaid Centennial(please circle which applies): Molina BCBS Presbyterian United Healthcare

Patient Name:_____ Last menstrual period(if applicable)_____

Birth Weight _____ lbs/kg

Infants gestational age: ☐ Full-term ☐ Preterm-If preterm # of weeks____ ☐ Post-term

Type of Delivery: ☐ Vaginal ☐ C-section- If so please explain why:_____

Initial feeding of baby: ☐ Breast-current or for how long? ____ ☐ Formula

During Pregnancy where any of the following involved? Please check

- Smoking
- Alcohol
- Recreational Drugs
- Medications-Please list _____,_____,_____,_____

Were there any medical problems during pregnancy? Please check

- Diabetes
- Infections
- High Blood Pressure
- Breech Presentation
- Preterm labor – Please explain_____

Were there any problems during pregnancy?

_____

Were there any problems during the nursery stay? Please check

- Jaundice
- Prematurity
- Feeding difficulties
- Breathing problems
- Infections: _____
- Heart problems: _____
- Other _____

Hospitalization or Serious/Unusual Illnesses:
Name of Hospitals and when:

_____

Immunizations: up to date or not
Medication Allergy: _____. Food products Allergy: _____

Please list all medications and indicatons the patient is currently taking:

_____

Family History

Illnesses - Please check below if the patient or members of the patients family(parents, siblings, grandparents, aunts, uncles, first cousins) have any of the following illnesses or problems:

Patient	Patient's Family		Patient	Patient's Family	
☐	☐	Seizures / convulsions	☐	☐	Early stroke / heart attack (before age 45)
☐	☐	Abnormal heart rhythm	☐	☐	High blood pressure at young age.
☐	☐	Wheezing / asthma	☐	☐	High cholesterol > 500 mg%
☐	☐	Frequent pneumonia	☐	☐	Heart murmur / Heart defects
☐	☐	Deafness	☐	☐	Chest wall deformities
☐	☐	Genetic disease / Down syndrome	☐	☐	Cardiac sudden death in young adult
☐	☐	Sickle cell anemia/ blood problems	☐	☐	Aortic Aneurysm
☐	☐	Passing out / fainting	☐	☐	Sudden infant death syndrome, SIDS.
☐	☐	Other illnesses _____	☐	☐	Mitral valve prolapse / Marfan syndrome

General Health:	**First Name**	**Health problems - if any**
Mother		
Father		
Siblings		

Have any of the childs brothers or sisters passed away? ☐ No ☐ Yes - Explain_____

Is Patient Adopted? ☐ No ☐ Yes

Does Patient know? ☐ No ☐ Yes

If there is any information you know regarding birth parents health history please explain:

_____

_____

South Plains Pediatric Cardiology, P.A.
Somkiat Sopontammarak, M.D., F.A.A.P., FA.C.C

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We do file insurance for office visits and hospital services performed by Dr. Sopontammarak (Sam). Echocardiograms ordered by Dr. Sopontammarak (Sam) are also filed with the insurance provided to us.

Payments for services provided are due at the time of each visit. We will provide you with a receipt suitable for maintaining your records.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. I hereby authorize Somkiat Sopontammarak, M.D. to release any and all medical information pertinent to, (patient's name) _____ case to any insurance company(s), attorney or adjustor involved with my case in order to process claims for reimbursement for services rendered by Somkiat Sopontammarak, M.D.

2. I hereby authorize and assign direct payment to my physician of any sum I now or hereafter owe to the facility by my insurance company(s) obligated to reimburse me for the charges for services or otherwise obligated to make payment to me, or my physician based in whole, or in part upon the charges made for services. If my insurance policy prohibits direct payment to you, I hereby instruct said company(s) to make the check payable to my physician(s). I further instruct my insurance company to mail said check directly to provider. I understand that this assignment of benefits covers any treatment rendered to the above mentioned patient by the physician(s).

3. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. The signature on this document authorizes release of any information to the insurer or agency shown on the patient information form. The patient is responsible for the deductible and amounts non-covered by their insurance company(s).

_____ _____

Date Print Patient's Name

_____ _____

Witness Responsible Party's Signature

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority