

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

SPPC Past Health History and Family Health History intake form:

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 - How often? _____
- Alcohol - How often? _____
- 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:

Please list all Allergies to food, medications or other?

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

Family Health 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's		Patient's	
Patient	Family	Patient	Family
<input type="checkbox"/>	<input type="checkbox"/> Kidney / bladder problems or infections	<input type="checkbox"/>	<input type="checkbox"/> Genetic diseases or Down syndrome
<input type="checkbox"/>	<input type="checkbox"/> Frequent Strep sore throat	<input type="checkbox"/>	<input type="checkbox"/> Seizures / convulsions
<input type="checkbox"/>	<input type="checkbox"/> Croup/Noisy breathing/Snoring	<input type="checkbox"/>	<input type="checkbox"/> Early stroke / heart attack (age 50 or less)
<input type="checkbox"/>	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure at kids / teenagers / young adult.
<input type="checkbox"/>	<input type="checkbox"/> Wheezing / asthma	<input type="checkbox"/>	<input type="checkbox"/> High cholesterol > 500 mg%
<input type="checkbox"/>	<input type="checkbox"/> Frequent pneumonia	<input type="checkbox"/>	<input type="checkbox"/> Heart murmur / Heart defects
<input type="checkbox"/>	<input type="checkbox"/> Scoliosis / Bone diseases	<input type="checkbox"/>	<input type="checkbox"/> Chest wall deformities: caving in or pushing out.
<input type="checkbox"/>	<input type="checkbox"/> Sickle cell anemia/ blood problems	<input type="checkbox"/>	<input type="checkbox"/> Sudden death during sports in kids / teenagers / young adult
<input type="checkbox"/>	<input type="checkbox"/> Deafness	<input type="checkbox"/>	<input type="checkbox"/> unexpected deaths (drowning, related to exercise, car crashes, falling from heights)
<input type="checkbox"/>	<input type="checkbox"/> Sudden infant death syndrome, SIDS.	<input type="checkbox"/>	<input type="checkbox"/> Aortic Aneurysm or Marfan syndrome
<input type="checkbox"/>	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/> Tall > 6 ' 6 " with heart disease
<input type="checkbox"/>	<input type="checkbox"/> Frequent fainting	<input type="checkbox"/>	<input type="checkbox"/> Abnormal heart rhythms: needs ablation / Pacemaker at young age
<input type="checkbox"/>	<input type="checkbox"/> Heart muscle diseases / cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/> Other illnesses _____

General Health:	First Name	D.O.B	Sex	Health problems - if any
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
&	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Have any of the child's 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:

Revised 05/23/2018

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

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