

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

Attends: stays home with family / daycare / Pre K / Kindergarten / __ grade

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 _____

Immunizations: up-to-date / delayed / no vaccine given.

Hospitalization or Serious/Unusual Illnesses:

Name of Hospitals and when:

Medication Allergy: _____ . Food products Allergy: _____

Please list all medications and indications 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:

<u>Patient</u>	<u>Family</u>	<u>Patient</u>	<u>Family</u>
<input type="checkbox"/>	<input type="checkbox"/> Seizures / convulsions	<input type="checkbox"/>	<input type="checkbox"/> Stroke / heart attack (before age 45)
<input type="checkbox"/>	<input type="checkbox"/> Abnormal heart rhythm in kids/ young adult	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure in kids / young adults.
<input type="checkbox"/>	<input type="checkbox"/> Wheezing / asthma	<input type="checkbox"/>	<input type="checkbox"/> High cholesterol in family
<input type="checkbox"/>	<input type="checkbox"/> Frequent pneumonia	<input type="checkbox"/>	<input type="checkbox"/> Heart murmur / Heart defects
<input type="checkbox"/>	<input type="checkbox"/> Deafness	<input type="checkbox"/>	<input type="checkbox"/> Chest wall deformities
<input type="checkbox"/>	<input type="checkbox"/> Genetic disease / Down syndrome	<input type="checkbox"/>	<input type="checkbox"/> Cardiac sudden death in young adult
<input type="checkbox"/>	<input type="checkbox"/> Sickle cell anemia/ blood problems	<input type="checkbox"/>	<input type="checkbox"/> Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/> Passing out / fainting	<input type="checkbox"/>	<input type="checkbox"/> Sudden infant death syndrome, SIDS.
<input type="checkbox"/>	<input type="checkbox"/> Other illnesses _____	<input type="checkbox"/>	<input type="checkbox"/> Mitral valve prolapse / Marfan syndrome

<u>General Health:</u>	<u>First Name</u>	<u>Health problems - if any</u>
Patient's Mother	_____	_____
Patient's Father	_____	_____
Patient's 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:

Living with: _____

Tobacco use in household / second hand smoke, including smoking outside the house : yes / no.

Parent marital status: _____

Revised 10/31/2018

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

History

Somkiat Sopontammarak, M.D.

Name: _____ Chart#: _____ DOS: ___/___/___

DOB: ___/___/___ AGE: ___Y/M/W/D S SEX: M / F

Ref Dr: _____ Reason: _____

Present Illness: _____	Notes:
Prenatal exposure to drugs, alcohol, illness: _____ _____	_____ _____
Prenatal and Developmental History: _____	_____ _____
Past medical history: _____	_____ _____
Current Medications: _____	_____ _____ _____
Allegies: _____	_____ _____
Family History: _____	_____ _____ _____ _____
Addendum: _____	_____ _____ _____

Physical Examination

Weight: _____ lbs _____ kg Height: _____ inch _____ cm SaO² _____
BP: _____ / _____ P _____ TEMP: _____ . _____ Head: _____

General Appearance: _____ _____ _____	Notes: _____ _____ _____
Chest Wall: _____ _____ _____	_____ _____ _____
HEENT: _____ Cardiovascular: _____ _____ _____	_____ _____ _____
Lungs: _____ _____ _____	_____ _____ _____
Liver: _____ _____ _____	_____ _____ _____
Conclusion: _____ _____ _____ _____	_____ _____ _____ _____
Echocardiogram: _____ _____ _____	_____ _____ _____
Impression: _____ _____ _____ _____	_____ _____ _____ _____
Disposition: _____ _____ _____	_____ _____ _____

Somkiat Sopontammarak, M.D. Signature