MacKoul Pediatrics of Cape Coral, FL

Patient Information

Full Name: ______________________________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apt./Unit #*

____
City *State* *Zip Code*

Home Phone: (   ) ______________ Cell Phone: (   ) ______________

Social Security or Government ID #: ______________________________

Birth Date: ______________ Primary Language: ______________

Gender: ____________ Ethnicity: ____________ Race: ____________

Dentist: ______________________________

Sibling(s) / Birthdate(s): ______________________________

____

Parents / Legal Guardians

Mother's Name: ______________________________

Birthdate: ______________ SS#: ______________

Address: ______________ Email Address: ______________

Home Phone: (   ) ______________ Cell Phone: (   ) ______________

Occupation: ______________ Employer: ______________

Father's Name: ______________________________

Birthdate: ______________ SS#: ______________

Address: ______________ Email Address: ______________

Home Phone: (   ) ______________ Cell Phone: (   ) ______________

Occupation: ______________ Employer: ______________

Primary Insurance

Insurance Company Name: ______________________________

Insurance Address: ______________________________

Insured Name: ______________________________

Policy #: ____________ Group #: ____________ Group Name: ____________

Referral Information

How Did You Hear About Us? ☐ Friend/Family ☐ Internet (Google) ☐ Social Media ☐ Other

Other: ______________________________

Emergency Contact Information

Full Name: ______________________________

Last *First* *M.I.*

Address: ______________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Primary Phone: **( )** __________ Alternate Phone: **( )** __________

Relationship: ______________________________

We are committed to providing your child with the best possible care. If have medical insurance we want to help you receive your maximum allowable benefits. To achieve this, we need your assistance and understanding of our payment policy

1. Our office submits all insurance claims for you. We must have your current insurance information, including a copy of your insurance card, the claims address, policy and group numbers.
2. Payment for services not covered by your insurance is due at the time of your visit
3. Payment is due at the time of the visit if you have third party insurance or a policy that does not send payment directly to our office
4. Copayments are due at the time of your visit
5. We accept cash, personal checks, Visa, Mastercard and Discover
6. Returned checks are subject to a $30.00 fee
7. There is a $50.00 charge for no show appointments.
8. If you have any questions about the above information please don't hesitate to ask us, we are here to help you.
9. I hereby authorize Mackoul Pediatrics staff to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents for claims filed by this practice

$50.00 charge for all no show appointment Please Initial ____________

IF PATIENT IS A MINOR: I __________the __________of ________ hereby personally accept financially responsibility for professional services by MacKoul Pediatrics for the aforementioned child
Signed: Date

I/We hereby authorize my insurance benefits, to be paid directly to the physician and I/We hereby agree to be financially responsible for any amount not covered by insurance. I/We also authorize the physician to release any information required.

Patient/parent/guardian signature ______________________________ date ____________

Relationship to patient ______________________________

Family History

Does/did the patient's mother have any of the following illnesses?

- ☐ Diabetes ☐ High Blood Pressure ☐ Blood Disorders ☐ Migraine Headache ☐ None/Healthy
- ☐ Asthma ☐ Cancer ☐ Kidney Problems ☐ Other

Does/did the patient's father have any of the following illnesses?

- ☐ Diabetes ☐ High Blood Pressure ☐ Blood Disorders ☐ Migraine Headache ☐ None/Healthy
- ☐ Asthma ☐ Cancer ☐ Kidney Problems ☐ Other

Does/did any of the patient's siblings have any of the following illnesses?

- ☐ Diabetes ☐ High Blood Pressure ☐ Blood Disorders ☐ Migraine Headache ☐ None/Healthy
- ☐ Asthma ☐ Cancer ☐ Kidney Problems ☐ Other

Does/did the patient's paternal grandfather have any of the following illnesses?

- ☐ Diabetes ☐ High Blood Pressure ☐ Blood Disorders ☐ Migraine Headache ☐ None/Healthy
- ☐ Asthma ☐ Cancer ☐ Kidney Problems ☐ Other

Does/did the patient's paternal grandmother have any of the following illnesses?

- ☐ Diabetes ☐ High Blood Pressure ☐ Blood Disorders ☐ Migraine Headache ☐ None/Healthy
- ☐ Asthma ☐ Cancer ☐ Kidney Problems ☐ Other

Does/did the patient's maternal grandfather have any of the following illnesses?

- ☐ Diabetes ☐ High Blood Pressure ☐ Blood Disorders ☐ Migraine Headache ☐ None/Healthy
- ☐ Asthma ☐ Cancer ☐ Kidney Problems ☐ Other

Does/did the patient's maternal grandmother have any of the following illnesses?

- ☐ Diabetes ☐ High Blood Pressure ☐ Blood Disorders ☐ Migraine Headache ☐ None/Healthy
- ☐ Asthma ☐ Cancer ☐ Kidney Problems ☐ Other

Social History

What type of home does your child live in? (apartment, duplex, single family home, etc) ______________________

Is your home on city or well water? ______________________

What type of heating system does your family use? ______________________

Parents together? ☐ yes ☐ no

Does anyone in the family smoke? ☐ yes ☐ no

Are there any pets at home? ☐ yes ☐ no

Are there any guns in the home? ☐ yes ☐ no

Day care? ☐ yes ☐ no

Please complete your health questionnaire to the best of your ability

Ophthalmology

Any vision changes in the past year? ☐ yes ☐ no

Does your child wear glasses or contact lenses? ☐ yes ☐ no

Crossed or wandering eyes? ☐ yes ☐ no

Has your child ever had eye muscle surgery? ☐ yes ☐ no

Does your child have trouble reading or watching TV? ☐ yes ☐ no

ENT/Respiratory

Has your child had frequent ear infections? ☐ yes ☐ no

Does your child have chronic ear drainage? ☐ yes ☐ no

Does your child have speech problems or speech delay? ☐ yes ☐ no

Does your child suffer from hearing loss? ☐ yes ☐ no

Does your child have chronic nasal congestion? ☐ yes ☐ no

Has your child ever had ear tubes put in? ☐ yes ☐ no

Does your child get frequent colds/upper respiratory infections? ☐ yes ☐ no

Does your child sneeze frequently or excessively? ☐ yes ☐ no

Does your child have seasonal runny nose or allergies? ☐ yes ☐ no

Does your child get frequent nose bleeds? ☐ yes ☐ no

Does your child get frequent sore throats or strep throat infections? ☐ yes ☐ no

Has your child has his/her tonsils removed? ☐ yes ☐ no

Dental

Has your child ever had a cavity? ☐ yes ☐ no

Does your child have any bite (occlusion) defects? ☐ yes ☐ no

Dermatology

Does your child have any birthmarks or moles? ☐ yes ☐ no

Does your child have acne? ☐ yes ☐ no

Does your child have a heavy tan or often sunburned? ☐ yes ☐ no

Please fill our your child's surgical history

Surgery	Date

Please list any hospitalizations

Hospitalization	Date

Please list any allergy information if you have not already submitted it. Enter 'NONE' if there are no known allergies.

Allergic to [Drug/Non-Drug]	Allergic Reaction