Apex Pediatrics

A Medical Group

Mohammad Kanakriyeh, M.D.

PATIENT REGISTRATION

Patient's Name (L, F M) Nombre del Paciente		Date of Birth: Fecha de Nacimiento:	Sex: ☐ M ☐ F Sexso:
Address: Domicilio:	City: Ciudad:	State: Estado:	Zip: Zona Postal:
Home Telephone: ( ) - Telefono de la casa:	Work Phone: Mom: ( ) - Telefono Del Trabajo: Dad: ( ) -		Social Security Number: – –
Mother's Name: Nombre de La Madre:	DOB/NAC: / /	Employer /Empleador	SS# – –
Father's Name: Nombre de Padre:	DOB/NAC: / /	Employer /Empleador	SS# – –
Legal Guardian:	DOB/NAC: / /	Employer /Empleador	SS# – –
Emergency Contact: Contactado de Emergencia:	Address: Domicilio:		Telephone: Telefono:

Insurance information

Primary Insurance: Aseguranza Primordial:	Subscriber: Suscritor Princpal:	ID#:
Address: Domicilio:	Telephone: ( ) -	Authorization#: Effective Date:
Secondary Insurance: Aseguranza Secundaria:	Subscriber: Suscritor Principal:	ID#:
Address: Direccion:	Telephone: ( ) -	Authorization#: Effective Date:
Medical: Medical#	**CCS** County ?	CCS Case #
Referring MD: Doctor Primordial:	Telephone: ( ) -	Medical Group:

Assignment of Benefits

I hereby authorize direct payment of medical benefits to Dr. Kanakriyeh for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Release of Medical Information

I hereby authorize Dr. Kanakriyeh, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of this assignment shall be valid as the original.

Asignacion de Beneficios

Yo authorizo pago directo de beneficios medicos al Dr. Kanakriyeh por servicios rendidos por e'l o toddos bajo su supervision. Yo tengo entendido quesoy responsable de pagar cualquir ballance no pagado por mi seguro.

Salida de Informacion Medica

Yo authorizo Dr. Kanakriyeh a entregar cuaquier informacion medico or incidental que sea necessario por cuidado medico o en la processesacion de applicaciones for beneficios financiales

Signature: ..... **Date:** .....

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A Medical Group
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INITIAL PATIENT QUESTIONAIRE

PATIENT NAME: **DOB:** **DATE:**

Please check [Y] yes or [N] no, circle or explain where required, N/A for not applicable

Reason for today's visit : Completed by ..... Relation.....

Previous medical care- Dr. ..... Dental care [Y] [N] ..... Eye Exam [Y] [N] .....

PREGNANCY AND BIRTH

Mother's age at pregnancy ? .....

Place of birth ..... Hospital : .....

Prgnancy: Normal (Y) Complicated (Y) (N) .....

Any illness during pregnancy ? (Y) (N) .....
Medications during pregnancy ? (Y) (N) .....
Smoking - alcohol -street drugs - during pregnancy ? (Y) (N).....
Was baby born premature - Late - or on time ? .....

Type of delivery?..... Birth weight ..... Length .....
Complications ? ..... Apgar .....
Problems with baby at birth? Breathing [Y] [N] Jaundice [Y] [N]
Problems soon after birth? Nursery or Home ?.....

PAST MEDICAL HISTORY

Allergy ? Food [Y] [N] Animals [Y] [N]

Allergies: Insects [Y] [N] Medications? [Y] [N] .....

Immunizations - up to date ? [Y] [N] Reaction to vaccine ? [Y] [N]

Hospitalizations: (when- where- why ?) .....

Serious injuries (when- where ?) .....

CHILDHOOD DISEASES:

Measles:	[Y] [N]	Meningitis:	[Y] [N]
Mumps:	[Y] [N]	Aneamia:	[Y] [N]
Whooping Coughs:	[Y] [N]	Bleeding Tendency:	[Y] [N]
Chicken Poxs:	[Y] [N]	Blood Transfusions:	[Y] [N]
German measles:	[Y] [N]	Asthma /Wheezing:	[Y] [N]
Scarlet fevers:	[Y] [N]	Eczema /Hives:	[Y] [N]
Rheumatic fever:	[Y] [N]	Seizures:	[Y] [N]
Hepatitis:	[Y] [N]	Vision Problems:	[Y] [N]
Ear Infections:	[Y] [N]	Hearing Problems:	[Y] [N]
Throat Infections:	[Y] [N]	Other illness:	[Y] [N] .....

FEEDING & NUTRITION

Breast fed ? [Y] [N] No of months .....
Formula ? [Y] [N] Brand .....
Special Diet [Y] [N] .....
Regular Diet [Y] [N] .....

FAMILY PROFILE

Parents- Married ? [ ] Seperated ? [ ] Divorced ? [ ]

Father's Age ? ..... Highest school grade? ..... Health ? .....

Mother's Age? ..... Highest school grade? ..... Health ? .....

(List child's brothers & sisters and their ages)

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FAMILY HISTORY

List all blood relatives of your child who have had the following problems - use abrev. (F) Father, (M) Mother, (B) Brother, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Anemia, blood disease : .....
Asthma : .....
Mental Retardations : .....
Drug Problem : .....
Alcoholism : .....
Cancer : .....
Aids : .....
Cystic Fibrosis : .....
Musc. Dystrophy : .....
Tuberculosis : .....
Arthritis : .....
Epilepsy/ Seizures : .....
Migraine : .....
Early deafness : .....
Diabetes : .....
Birth Defects : .....
Sudden Infant Death : .....
High Blood Pressure : .....
Cholesterol Problem : .....
Adult heart disease : .....
Congenital heart Defects : .....
Heart murmurs : .....

DEVELOPMENT & BEHAVIOR

Age at child -

Sat Alone ..... Walked ..... Used Sentences.....
Toilet Trained ..... Bicycled .....

Development compaired to ether children?
Grade in school: ..... Problems a school ? [Y] [N]
Getting along with other children: [Y] [N]

Learning Problems?: [Y] [N] .....
Behavioral Problems ?: [Y] [N] .....
Hobbies- Sports ?: [Y] [N] .....
Use of Street Drugs ?: [Y] [N] .....
Alcohol?: [Y] [N] .....
Social activities? [Y] [N] .....

Bad Habits?: [Y] [N] Bedwetting?: [Y] [N]
Nail Biting?: [Y] [N] Sleeping?: [Y] [N]

SYNOPSIS :

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CONSENT TO TREATMENT

For: _____
Name of Patient

1. CONSENT TO TREATMENT. The undersigned consents to health care encompassing routine diagnostic procedures and other health services rendered to the patient by Mohammad Kanakriyeh, M.D., and duly authorized agents and personnel.

2. NO GUARANTEES. It is understood that the practice of medicine and surgery and the rendering of health care is not exact science and that no guarantees have been made as to the results of treatments, examinations or other health services rendered by Dr. Kanakriyeh.

3. RELEASE OF INFORMATION. The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, Dr. Kanakriyeh may disclose portions of the patient's records, including his/her medical records, to any person or entity which is or may be liable for all or any portion of Dr. Kanakriyeh's reimbursement for charges. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.

4. ASSIGNMENT OF BENEFITS. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Dr. Kanakriyeh of any insurance benefits otherwise payable to or on behalf of the undersigned for treatment and health care services rendered by the patient's health plan at a rate not to exceed Dr. Kanakriyeh's regular charges. It is agreed that payment to Dr. Kanakriyeh, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood that he/she is financially responsible for charges not covered by this assignment pursuant to Paragraph 5 below.

5. FINANCIAL AGREEMENT. If the patient is not a member of an HMO at the time services are rendered, the undersigned agrees, whether he/she signs as agent or as patient, that he/she hereby individually obligates himself/herself to pay the account of Dr. Kanakriyeh in accordance with the regular rates and terms of Dr. Kanakriyeh. Should the account be referred to an attorney or collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

6. CERTIFICATION. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative or duly authorized by the patient as the patient's general agent to execute this Agreement and to accept its terms.

_____ _____
Date and time of signing Signature Patient/Parent/Guardian/Conservator

_____ _____
Witness If signed by other than patient, indicate relationship

Financial Responsibility Agreement by Person Other Than the Patient, or the Patient's Legal Representative: I agree to accept financial responsibility for services rendered to patient and to accept the terms of the Financial Agreement and Assignment of Insurance Benefits Provisions above.

_____ _____
Date and time of signing Financially responsible party

_____
Witness