Donna Zappi Fox, M.D.
Pediatrics

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NAME _____ MALE – FEMALE

ADDRESS _____

_____

PHONE _____ CELL MOM _____ CELL DAD_____

WORK MOM_____WORK DAD_____

BIRTH DATE _____ AGE 1ST SEEN IN THIS OFFICE_____

BIRTHPLACE _____

OBSTETRICIAN _____ REFERRED BY _____

FATHER'S NAME _____ BIRTHDATE _____

SOCIAL SECURITY NUMBER _____

OCCUPATION _____ EMPLOYER _____

MOTHER'S NAME _____ BIRTHDATE _____

SOCIAL SECURITY NUMBER _____

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT (other than parent) _____

PHONE _____ CELL _____ RELATIONSHIP _____

SIBLINGS _____

FAMILY HISTORY (circle any illnesses below which run in the family):

ASTHMA / ALLERGIES KIDNEY DISEASE SEIZURES

BLOOD DISORDERS HEART DISEASE / HIGH BLOOD PRESSURE

OTHER_____

PATIENT'S MEDICAL HISTORY:

BIRTH WT_____LENGTH _____ D/C DATE _____

BIRTH RECORD: MATERNAL AGE / PARIDA /GESTATION_____

COMPLICATIONS/LABOR/DELIVERY/JAUNCICE _____ APGAR_____

MOM / BABY BLOOD TYPES _____ FEEDINGS _____

HOSPITALIZATIONS_____

_____

SURGERIES_____

_____

SERIOUS INJURIES/SERIOUS ILLNESSES_____

_____

CHRONIC MEDICATIONS _____

_____

GUARANTOR INFORMATION (IF SOMEONE OTHER THAN PARENT):

RESPONSIBLE PARTY'S LAST NAME: _____ FIRST _____ MI_____

RELATIONSHIP _____ PHONE _____ CELL _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY #: _____BIRTHDATE_____

EMPLOYER _____OCCUPATION_____

AGREEMENT OF PROFESSIONAL SERVICES: I agree that the determination of professional services to be rendered by my physician is a matter concerning my physician and myself. I understand that I am responsible for payment of these fees regardless of insurance benefits. Neither my physician nor myself will permit a third party to determine what medical services I need or what my physician should charge for these services. I also agree that in the event my account becomes delinquent, I am responsible for all costs incurred in the collection of my account if referred to an outside agency.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: This form authorizes Dr. Donna Fox to release confidential information in regards to my professional medical care to identifiable persons associated with my insurance company.

ASSIGNMENT AGREEMENT: I hereby assign, convey, and transfer all of my rights which exist under my contract of health insurance for reimbursement of medical benefits to the physician or supplier of services described in block 13 of the claim form. In addition to authorization for payment for such medical benefits, I also assign, convey and transfer to my physician any and all rights which I have under my health insurance contract and/or which to legal and judicial enforcement of this claim, as well as for penalties, cost of services for collection, and attorney's fees resulting from the failure to satisfy this claim within the time allowed by law.

DATE: _____ SIGNATURE: _____ (Patient or Responsible Party)