Patient's Name: _____ Date Of Birth: _____

Male _____ Female _____ Social Security #: _____

Address: _____City: _____ State: _____ Zip: _____

Home#: _____ Cell#:_____ Work#: _____

I AUTHORIZE LUISA GOMEZ MCELROY, MD TO LEAVE A MESSAGE OR APPOINTMENT REMINDER AT PHONE: __HOME __CELL __WORK__EMAIL: _____

Parent 1 Name: _____ D.O.B. _____

Parent 1 Address: _____

Home#: _____ Cell#:_____ Work#: _____

Parent 1 Employer: _____Parent 1 Occupation: _____

Parent 2 Name: _____ D.O.B. _____

Parent 2 Address: _____

Parent 2 Employer: _____ Parent 2 Occupation: _____

Home#: _____ Cell#:_____ Work#: _____

Patient Legal Guardian: __ Parent 1 __ Parent 2 __ Other: _____

Patient Responsibility Party From Above: _____ __Parent 1 __ Parent 2
(PERSON RESPONSIBLE FOR PAYING YOUR MEDICAL BILLS, OTHER THAN INSURANCE COMPANY)

Emergency Contact: _____Relationship to Child: _____Phone: _____

Pharmacy: _____ Ph #: _____

Address: _____

Primary Insurance Name: _____

ID #: _____ Grp#: _____ Co-pay: _____ Deductible: _____

Subscriber (Policy Holder): _____ Relationship to patient: __Self __Father __ Mother __Grandparent

Claims Address: _____

Secondary Insurance Name: _____

ID #: _____ Grp#: _____ Co-pay: _____ Deductible: _____

Subscriber (Policy Holder): _____ Relationship to patient: __Self __Father __ Mother __Grandparent

Parent's Signature: _____ Date: _____

PATIENT NAME: _____ D.O.B.: _____ MALE/FEMALE

Patient/Family History:

FAMILY HISTORY: Please check any of the following that pertains to your family :

Deafness		Who:
Nasal Allergies		Who:
Asthma		Who:
Tuberculous		Who:
Heart Disease (Before 50yrs old)		Who:
High Blood Pressure (Before 50yrs old)		Who:
High Cholesterol		Who:
Anemia		Who:
Bleeding Disorder		Who:
Liver Disease		Who:
Kidney Disease		Who:
Diabetes (Before 50yrs old)		Who:
Bed wetting (After 10yrs old)		Who:
Epilepsy or Seizures		Who:
Alcohol Abuse		Who:
Drug Abuse		Who:
Mental Illness		Who:
Mental Retardation		Who:
Immune Problems, HIV, AIDS		Who:

Additional Family History:

_____

_____

PAST HISTORY: Please check any of the following if your child has, or have had any of the following:

Chickenpox		When:
Frequent Ear Infections		Explain:
Problems with ears or hearing		Explain:
Nasal Allergies		Explain:
Problems with eyes or vision		Explain:
Asthma, bronchitis, bronchiolitis, or pneumonia		Explain:
Any heart problem or heart murmur		Explain:
Anemia or bleeding problem		Explain:
Blood Transfusion		Explain:
Frequent abdominal pain		Explain:
Constipation requiring doctor visits		Explain:
Bladder or kidney infection		Explain:
Bed wetting (After 5 yrs old)		Explain:
(For Girls) Has she started her menstrual period?		Explain:
(For Girls) Are there problems with her periods?		Explain:
Any chronic or recurrent skin problem (acne, eczema, etc)		Explain:
Frequent Headaches		Explain:
Convulsions or other neurologic problem		Explain:
Diabetes		Explain:
Thyroid or other endocrine problem		Explain:
Any other significant problem		Explain:
Use of alcohol or drugs		Explain:
ADHD/ADD		Explain:

PATIENT HISTORY

Patient Name: _____ D.O.B. _____

BIRTH HISTORY:
Pregnancy or Delivery Complications: Yes/No If yes, please explain: _____
_____
Type of delivery: Vaginal or C/S Term/Premature: _____ Weeks
Hospital Name: _____ Birth Weight: _____ Length: _____
Discharge Weight: _____ Blood Type: _____ Jaundice: Yes/ No
While mother was pregnant did she smoke/drink/use drugs or medications?
If you circled any, please list:
_____

GENERAL HEALTH:
Does your child have any serious illness or medical condition? Y/N
Explain: _____
_____

Has your child had any serious injuries or accidents? Y/N
Explain: _____
_____

Has your child had any surgeries or hospitalizations? Y/N
Explain: _____
_____

Please list any allergies to medications: _____
_____

Please list any medications child is currently taking: _____
_____

SOCIAL HISTORY:
Languages Spoken: _____/_____ Race: African American/Black/
American Indian/Alaska Native/Asian/Native Hawaiian or Other Pacific Island/White

Ethnicity: Hispanic/Non-Hispanic/Declined

Persons in Household: Adults____ Kids ____ Type of Home: House/Apartment/Other: _____
Type of Water: Well/City Exposure to Smoke: Yes/No

Pets: _____

Parent's Signature: _____ Date: _____

OFFICE POLICIES

Patient's Name: _____ D.O.B. _____

MEDICATION REFILL POLICY **INITIAL: _____**

*I understand that medication will not be called to the pharmacy without child being evaluated in the office, to make sure medications are needed and to make sure no other medical condition goes untreated.
*I understand that I should allow 48 hours for medication refills, and that I will need to call prior to my child running out of medication. Children who are on ADD/ADHD medications need to be followed closely and must be seen every 3 months.

APPOINTMENT POLICY **INITIAL: _____**

*I understand that if I am more than 15 minutes late I may be asked to reschedule my appointment for a later time or for another day. This includes appointments made for the same day I called.
*I understand that I need to schedule an appointment for each child in my family who I want to have seen or who I have questions about. I understand that I will schedule all my children's appointments before I am in the room with the doctor.
*I understand that any time a physician is asked to see a child (even if it is just to "peek" in the child's ear) this information must be documented in the patient's chart and a claim for services must be filed. Any copayments or unpaid balances for these visits are my responsibility. Well Child Exam (Physical) appointments are scheduled differently than sick appointments. We cannot do a Well Child Exam (Physical) during a scheduled sick appointment. If your child is seriously ill on the day of a schedule Well Child Exam (Physical) appointment we will treat your child and ask you to reschedule the Well Child Exam (Physical) appointment. A Well Child Exam allows the physician to assess your child's development. It is difficult to do this when your child is seriously ill.
*I understand that whenever, I or someone else brings my child to LUISA GOMEZ MCELROY,MD I am authorizing treatment for that visit. If I do not attend an appointment, I will send a written authorization for treatment. LUISA GOMEZ MCELROY, MD may refuse treatment of my child if I do not provide the requested authorization.
* I understand some illnesses cannot be treated or fully diagnosed in a single visit so I may need to schedule a follow up appointment for my child. FOLLOW UP visits must be documented and are extremely important for the health of your child. PLEASE KEEP your appointment.
*I understand that "WALK INS" are strongly discouraged and appointments need to be scheduled prior to arrival to not disrupt the office flow. We will see your child if it is an emergent visit ASAP, and ask that you call on your way to the office if possible.

PAYMENT POLICY **INITIAL: _____**

*Any co-payments are due at the time of service; they are required by your insurance, so we will not be able to bill you. You are also responsible for any deductibles or co-insurances your insurance requires as well.
* I understand that I will be charged a $35 returned check fee for all returned checks.
* I understand that fees on monthly statements are due and payable within 30 days from the date of the statement and are considered delinquent thereafter.
*I do understand that fees may be charged for filling out forms. A fee of $10 will be charged for any additional forms to be completed by doctor. We will provide you with an estimate prior to forms being completed.

GUARANTOR LIABILITY RESPONSIBILITY **INITIAL: _____**

*I authorize the release of any medical information necessary to process an insurance claim.
*I authorize the insurance company to make payments on my behalf to the physician rendering service. Payment of any balance is my responsibility.
*I authorize you to give me reasonable and proper medical care by today's standards of care.
*I certify that all of the information given is true and correct to the best of my knowledge.

Parent/Guardian's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

My signature indicates that I acknowledge I have received and I have been given the opportunity to review the NOTICE OF PRIVACY PRACTICES at LUISA GOMEZ MCELROY, M.D.

SIGNATURE: _____

RELATIONSHIP: _____DATE: _____

CONSENT FOR TREATMENT OF MINOR

I _____, _____ of
(Your Name) (Relationship to patient)

_____ give the doctors and other health care workers of
(Patient's Name)

Luisa Gomez, McElroy, MD permission to examine, diagnose, counsel, _____
(Patient's Name)

if another AUTHORIZED adult (other than parents) accompanies the patient to the visit until further notice.

Name of authorized adult: _____Relationship:_____

Name of authorized adult: _____Relationship:_____

****Note to the parents of patients 16 and older: Each visit is confidential and the doctors and other healthcare workers of Luisa Gomez McElroy, M.D. are not privileged to discuss these visits with you unless the patient consents to disclose the information to you.****

Parent/Guardian Signature: _____

Date: _____

Authorization to Disclose Health Information to
Dr. Luisa Gomez McElroy, MD

Patient Name: _____DOB: _____
Address:_____City_____State_____Zip_____
Phone #: _____

Obtaining Records From:

Provider Name: _____
Provider Address: _____
_____
Provider Phone #_____ Fax #: _____

I understand that information in my record may include information related to sexual history, sexually transmitted disease, HIV or AIDS, psychiatric or mental health services, as well as drug and alcohol use. **NO DISCS**

Please release all records regarding the above patient to:

Luisa Gomez McElroy, MD
10860 Sheldon Road
Tampa, FL 33626
(813) 792-1905 Fax: (813) 926-1502

Please include immunization records, hospitalization reports, allergies, medications, last well visit, and any other pertinent records.

_____Printed name of parent

_____Signature of parent

_____Date

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility. This authorization will automatically expire 12 months after the date signed.

VACCINE CONSENT

In order to become a patient at Luisa Gomez McElroy, MD, I agree that my child will be given/administered the appropriate vaccines that are required for enrollment in Florida Public Schools.
If vaccines are refused for my child, I understand that my child will no longer be under the care of Luisa Gomez McElroy, MD and should seek medical care elsewhere.

Name of patient:
_____

Patient DOB:
_____

Printed Name of Parent:
_____

Signature of Parent:
_____

Date:
_____