WINDERMERE
Medical Center

Primary Care | Walk-in Care | Chiropractic Care

PATIENT REGISTRATION

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First/Last Name: ____ Date of Birth/Age: ________________

Mailing Address: ____ City/State/Zip: _______________________

Home Phone: ___________________ Cell Phone: ___________________ Other Phone: ______________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Sex: ☐Male ☐Female

Social Security #: _______ - _____ - _______ Email address: ____

EMERGENCY CONTACT

Name: _______________________________________ Relation: ____

Contact Number: ______________________________ Address: ____

Referral Source:

- ☐ Website/Internet Search ____________________________
- ☐ Patient Referral ____________________________
- ☐ Magazine/Name ________________________________
- ☐ Direct Mail ________________________________
- ☐ Newspaper/Name _______________________________
- ☐ Chamber of Commerce ______________________

INSURANCE

Insurance: _______________________________________ Policy Number: _______________________________________

Policy Holder SSN: _______ - _____ - _______ DOB: ___________ Relation to Patient: _________________________

Secondary Insurance: ______________________________ Policy Number: _______________________________________

Policy Holder SSN: _______ - _____ - _______ DOB: ___________ Relation to Patient: _________________________

OFFICE USE ONLY

SCANNED PICTURE ID: _________ SCANNED ID/INSURANCE CARD: _________

ALL FORMS REVIEWED BY: _________

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Marketplace/ObamaCare Insurance Financial Policy

The Affordable Care Act (ACA) created the Advance Premium Tax Credit (APTC) to assist patients in paying their health insurance premiums. This tax credit does not subsidize the entire premium, and as such, you are responsible for paying the remainder portion of your health insurance premium.

If you purchased your health insurance through the ObamaCare website (www.healthcare.gov), you are required to make your monthly premium payments to avoid a 90-day grace period, which puts you at risk of losing your coverage if payment is not made in full at the end of the grace period.

According to federal regulation §156.270, your insurance carrier is required to notify us if you have defaulted on your premium payments. If we receive such notification from your insurance carrier, we will send you a statement for the balance due on your account for services rendered at Windermere Medical Center. Your account will be placed in a self-pay status until your premiums payments are made in full (we will call your insurance carrier for confirmation of payment). If your policy is canceled due to non-payment of premiums, your account with Windermere Medical Center will remain in a self-pay status.

If your balance with Windermere Medical Center is not paid in full after 90 days, your account will be forwarded to a collection agency to collect on your account.

By signing this policy below, the patient/parent confirms that:

I understand and acknowledge that I am personally responsible to pay Windermere Medical Center in full for services that my health insurance payer will not cover due to non-payment of my health insurance premiums. I further understand and acknowledge that my account will be placed in a self-pay status, and I am at risk for my account being forwarded to a collection agency if I do not pay my balance in full.

I confirm that I have **not** purchased insurance through ObamaCare (www.healthcare.gov). I have insurance through my employer or another private/commercial or Medicare plan, or I am a self-pay patient.

______________________________________ ____________________
Patient Name/Signature Date

I confirm that I **have** purchased insurance through ObamaCare at www.healthcare.gov; I will comply with this policy regarding my account.

______________________________________ ____________________
Patient Name/Signature Date

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Pediatric Health History Form

Child's Name: ______________________________________ Date of Birth: _______________ Age:______

Child's Previous Doctor/Primary Care Provider: ____

Present Health Concerns:____

Medicines/Vitamins/Herbal/Home Remedies:______ Allergies/Reactions to Medicines/Vaccinations:___

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Is your child vaccinated? ☐ Yes ☐ No

If yes, are they: ☐ Up to date ☐ Missing Immunizations

My child has never been immunized ☐

PREGNANCY & BIRTH

Where was your child born? ____

Is the child yours by: Birth ☐ Adoption ☐ Stepchild ☐ Other: ______________________

Full Term Pregnancy ☐ Premature Birth ☐ _______ weeks gestation

Normal/Vaginal Delivery ☐ Cesarean Delivery ☐

Complications: ____

Birth Weight: _______ lbs ______oz Length: _______ inches APGAR score: 1 min: ___ 5 min: ___

Please indicate any medical problems during the baby's newborn period: None ☐

Other problems: ____

PAST MEDICAL HISTORY (Please describe any major medical problems and their dates):

____

____

____

Hospitalizations/Operations (with dates): **Broken bones or severe sprains** (with dates):

____________________________________ ____

NUTRITION & FEEDING

Has your child had any feeding/dietary problems? ☐ No ☐ Yes

If yes, specify:

____

Milk intake now: Type: ☐ Cow's milk – (○ Nonfat ○ 1% fat ○ 2% fat ○ Whole milk)

☐ Soy milk ☐ Rice milk Average ounces per day (Note: 8 ounces = 1 cup): ________

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DEVELOPMENT (*At what age did your child):*

Sit alone: _______ Walk alone: _______ Say words: _______ Toilet train (daytime): ______

Girls only: Age at first menstrual period: _______

DENTAL HISTORY Is your child been seen regularly by a dentist? ☐ No ☐ Yes

Water Source: City or Well? ________

EXPOSURES/HABITS

Any concerns about lead exposure? (old home/plumbing/peeling paint) ☐ No ☐ Yes
Is your child exposed to smoke in the house? ☐ No ☐ Yes

FAMILY HISTORY (*Please indicate the current status of your immediate family members. Indicate family members (indicate paternal or maternal side of the family) with any of the following conditions*):

Alcoholism: ______________________________
Cancer, specify type: ______________________
Heart Attack: _____________________________
Depression/Suicide: ________________________
Other: ___________________________________

High Cholesterol: _________________________
High Blood Pressure: ______________________
Stroke: __________________________________
Diabetes: ________________________________
Other: ___________________________________

SOCIAL HISTORY: (*Who lives at home?*):

Name Age Relationship

____

____

____

____

Are your child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

Mother's Occupation/Employer: ______________________Father's Occupation/Employer: ______________

Is your child currently in daycare (or has he/she ever been in daycare)? ☐ No ☐ Yes

CONCERNS ABOUT YOUR CHILD

☐ Alcohol use ☐ Tobacco ☐ Sexual activity ☐ Aggressive behavior

SCHOOL HISTORY: Did/does your child attend school or preschool? ☐ No ☐ Yes

Current grade: _______ Name of school: ______________________________________
Any concerns about school performance? : ☐ No ☐ Yes: _______________________________
Any concerns about relationship with: Teachers: ☐ No ☐ Yes ___________________________________

Students: ☐ No ☐ Yes ___________________________________
Sports/exercise: Type: ________________ How often? ____________ How long (minutes)? ________

SAFETY: When your child is in the car does he/she use: Infant seat ☐ Booster seat ☐ Seat belt only ☐