MEDICAL ASSOCIATES OF BREVARD

VIERA PEDIATRICS

Dr. Preeti Bimbrahw

8095 Spyglass Hill Road – Suite 104 ● Melbourne, FL 32940
Ph (321) 241-6400 ● Fax (321) 428-3945

PATIENT INFORMATION

PATIENT'S NAME_____ ☐ MALE ☐ FEMALE
(LAST) (FIRST) (MI) (NICKNAME)

DOB _____/_____/_____ **SOCIAL SECURITY #**_____-_____-_____

ADDRESS _____
(STREET) (CITY, STATE) (ZIP CODE)

HOME PHONE (_____) _____-_____ **CELL PHONE** (_____) _____-_____ **WORK PHONE** (_____) _____-_____

PHARMACY NAME_____**LOCATION**_____

MOTHER'S NAME (OR GUARDIAN) _____

DATE OF BIRTH _____ **SOCIAL SECURITY #**_____-_____-_____ **EMAIL ADDRESS**_____

ADDRESS _____
(STREET) (CITY, STATE) (ZIP CODE)

HOME PHONE (_____) _____-_____ **CELL PHONE** (_____) _____-_____ **WORK PHONE** (_____) _____-_____

EMPLOYER _____ **OCCUPATION**_____

FATHER'S NAME (OR GUARDIAN) _____

DATE OF BIRTH _____ **SOCIAL SECURITY #**_____-_____-_____ **EMAIL ADDRESS**_____

ADDRESS _____
(STREET) (CITY, STATE) (ZIP CODE)

HOME PHONE (_____) _____-_____ **CELL PHONE** (_____) _____-_____ **WORK PHONE** (_____) _____-_____

EMPLOYER _____ OCCUPATION_____

EMERGENCY CONTACT INFORMATION:

NAME_____

RELATIONSHIP_____ **PHONE #**_____

ADDRESS _____
(STREET) (CITY, STATE) (ZIP CODE)

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PATIENT'S NAME_____

INSURANCE INFORMATION – PRIMARY

INSURANCE CO. _____ **POLICY #** _____

POLICY HOLDER NAME_____ **DOB** ___/___/_____ **S.S. #** _____-_____-_____

INSURANCE INFORMATION - SECONDARY

INSURANCE CO. _____ **POLICY #** _____

POLICY HOLDER NAME_____ **DOB** ___/___/_____ **S.S. #** _____-_____-_____

Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of pocket, deductibles and non covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

SIGNED _____ **DATE** _____/_____/_____

PAST DUE ACCOUNTS

We will attempt to work out a payment schedule with you, however seriously delinquent accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

PLEASE INITIAL: _____

RETURNED CHECKS

For any returned checks, we will charge a $20 returned check fee. This fee plus the amount shown on the returned check must be paid by certified check, cash or credit card. Future payments to our office by patients who have had a returned check will need to pay by cash or credit card only.

PLEASE INITIAL: _____

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PATIENT'S NAME_____

HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

(Name)	(Relationship)	(Phone #)
(Name)	(Relationship)	(Phone #)

SIGNED _____ **DATE** _____/_____/_____

I authorize Medical Associates of Brevard to leave a detailed message on my answering machine.

SIGNED _____ **DATE** _____/_____/_____

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PATIENT'S NAME_____

Notice of Privacy Practices

I acknowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

_____

Print Name of Patient or Personal Representative

_____

Signature of Patient or Personal Representative Date

_____

Signature of Witness Date

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Medical History

CHILDS NAME: _____

PERSON COMPLETING FORM & RELATIONSHIP: _____

CHILDS DATE OF BIRTH: _____/_____/_____

MEDICATIONS:

Medications	Dose	How many times a day?

Surgical History

Please indicate any surgeries or procedures your child has had. Please include year of surgery/procedure performed.

FAMILY HISTORY

Please indicate if your child has a family history of any of the following:

Diagnosis	Family Member	Diagnosis	Family Member
*ADD/ADHD		*HEARING DISABILITY	
*ALCOHOL/DRUG ABUSE		*HIGH CHOLESTEROL	
*ALLERGIES		*HIGH BLOOD PRESSURE	
*ASTHMA		*HIV/AIDS	
* BIRTH DEFECTS		*LEARNING DISABILTY	
*BLOOD DISORDERS		*MENTAL ILLNESS	
*CANCER, TYPE		*MIGRAINES	
*HEART DISEASE		*SCOLIOSIS	
*DEAFNESS		*SEIZURE DISORDERS	
*DEPRESSION		*SPEECH PROBLEMS	
*DEVELOPMENT DELAY		*TB/LUNG DISEASE	
*DIABETES		*STROKE	
*GENETIC DISORDER		*THYROID DISEASE	
*HEPATITIS/LIVER DISEASE			

SIGNATURE:_____
(PARENT/GUARDIAN)

PRINT NAME:_____

DATE:_____