

MOTHER'S MEDICAL HISTORY: (cont'd)

Blood Type/RH: Mother: _____ Father: _____

Cesarean Section Planned? Yes No Reason: _____

Previous Pregnancies

Year of Birth	Sex	Birth Weight	Special Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History: (list significant illnesses, surgery, injuries, hospitalizations, allergies, etc.)

Family Medical History: (List conditions of possible importance in the care of your infant such as diabetes, frequent miscarriages, epilepsy, bleeding disorder, serious anemia, muscular diseases, newborns with serious difficulties, twins, etc.)

Plans for Labor, Delivery, etc. (Comment regarding childbirth classes, father's participation in labor and delivery, preferred anesthesia, etc.)

FEEDINGS: Breast Bottle Undecided **MALE INFANT:** Circumcision: Yes No Undecided

List all other children who have been patients of Premier Pediatrics:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR INFORMATION RELEASE

1) I hereby assign and authorize payment of insurance benefits otherwise payable directly to Premier Pediatrics, for office or hospital services, which are not paid by me at the time of services.

2) I hereby authorize Premier Pediatrics to provide treatment for the patient listed above, and to release any and all information pertaining to office or hospital service rendered to me by said practice, including the diagnosis and treatment rendered to me by previous physicians, hospitals, or other medical facilities/personnel.

3) I understand that I am ultimately responsible for payment of any and all charges for treatment received and if this assigned claim is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full.

Parent/Caregiver Signature: _____ Date: _____