בס"ד

David E. Simai M.D.

Board Certified Pediatrician

660 Central Avenue, Suite #3
Cedarhurst, New York 11516
Tel. (516) 374-2228
Fax. (516) 374-2044
Email: DrSimaiPediatrics@Gmail.Com
Website: www.DoctorSimai.com

Patients Name: ____ **Gender:** _______ **DOB:** ________________
Address: ______________________________**City/Zip:** _____________ **State:** _______ **Phone:** ___________

Fathers Name: ____ **SS#:** ________________ **DOB:** ________
□**Email:** ____________________________ **Cell:** ________________ **Occupation:** _______________________

Mothers Name: _________________ **Maiden Name** _______________ **SS#:**___________ ___**DOB:** _______
□**Email:** ____________________________ **Cell:** _______________**Occupation:** _________________________

Parents Marital Status: _________**Emergency Contact:** __________ **Phone number:** __________________

INSURANCE INFORMATION – PLEASE ENTER ALL INSURANCE POLICIES THAT YOU HAVE

Primary Insurance: _______________________**Insurance ID:** ____________________ **Deductible** □**yes**

Primary Card holder: ___________________ **Relationship to Patient:** ____________ **DOB:** __________

Secondary Insurance: ___________________________________ **Insurance ID:** ____________________

DIAGNOSIS AND TREATMENT I, ___________________________________, authorize the staff of **Urgent One Medical Care P.C.** and those responsible for the care of ______________________________ to administer and perform such treatment and procedures as are considered necessary or advisable in the diagnosis of this patient. I understand that the practice of medicine and dentistry and podiatry is not an exact science and acknowledge that no guarantees have been made as to the result of my care. I also understand that this consent allows for the exchange of medical information relevant to my care with other health care providers. **FINANCIAL AGREEMENT** I, the undersigned, acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand **Urgent One Medical Care P.C.** Staff is providing care and treatment to ____________________ and agrees to pay charges for such care and treatment. I understand the insurance benefits are subject to verification and that I am responsible for charges not covered by insurance in accordance with the service policies, rate and terms established by the office of **Urgent One Medical Care P.C.** I understand that if any of my insurance carriers require pre-certification or pre-approval of my admission that I accept full responsibility for obtaining such authorization. I also understand that balances resulting from my failure to obtain such authorization from my carrier are my responsibility. **RELEASE OF MEDICAL INFORMATION** I, the undersigned, authorize and direct **Urgent One Medical Care P.C.** staff, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my care, all information needed to substantiate payment for such care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. **ASSIGNMENT OF INSURANCE BENEFITS** I, the undersigned, assign, transfer, and set over **Urgent One Medical Care P.C.** and staff sufficient monies and / or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my care to cover the costs and the care and treatment rendered to myself or my dependent in the specified office. MEDICAID AUTHORIZATION AND ASSIGNEMENT I, the undersigned, certify that the information given by me in applying for payment under TITLE XVIII (Medicaid) of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicaid for payment to me. I certify that I am over the age of 18 years or that I am under the age of 18 years but am married of the parent of a child.

SIGNATURE__________________________ **DATE**___________________

RELATIONSHIP OF PATIENT_____________ **WITNESS TO SIGNATURE**______________

____

For Office Use Only: ☐ **Constant Contact** **Entered by** ____________________________________

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NOTICE OF PRIVACY PRACTICES

Urgent One Medical Care P.C.
660 Central Avenue, Suite #3
Cedarhurst, NY 11516
Tel. (516) 374-2228

I have received a paper copy of this privacy notice and consent to the uses and disclosures it describes.

Signature: ____

Print Name: ____

Patient (s) Name: ____

Date: _______________________

I would like to make the following special request of confidential communications (If Applicable):

- **Exclude** communications with:
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- **Include** communications with:
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

____

Signature: **Date:**

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Patient History Form

David E. Simai, M.D.

Patients Name: ___________________ **Name of Previous Doctor:** ________________________

1. Birthplace___________________________________
2. Birth weight_________________________________
3. Birth length__________________________________
4. Pregnancy problems__________________________
5. Delivery problems____________________________
6. Gestational age: ____________________________
7. Nursery problems: ___________________________

Family History:

8. Health of Father_____________________________
9. Health of Mother____________________________
10. # and Health of siblings _______________________
11. Family Diabetes ______________________________
12. Family Allergies ______________________________
13. Family Convulsions/seizures ___________________
14. Family high cholesterol _______________________
15. Family TB/Tuberculosis _______________________

Growth and Development:

16. Concerns with weight gain? __________________
17. Concerns with height? ______________________
18. Behind in development? _____________________
19. School problems? _________________________
20. Sees counselor? __________________________
21. Problems sleeping? _________________________

Who may we thank for referring you?

____

22. Problems eating? ___________________________
23. In bed with a bottle? _________________________
24. Special diets? _____________________________
25. Taking vitamins ____________________________
26. Taking fluoride? ____________________________
27. Had chickenpox? ___________________________

Any problems with:

28. Ears ______________________________________
29. Sinuses ____________________________________
30. Throat _____________________________________
31. Lungs ______________________________________
32. Heart ______________________________________
33. Kidney/bladder _____________________________
34. Bones/joints ________________________________
35. Skin _______________________________________
36. Blood ______________________________________
37. Seizures ___________________________________

- **Was your child ever Hospitalized (list dates and reasons)**

  ____
  ____
  ____

- **Allergic reactions to any of the following?**

  Medications: ______________________________
  Insects: __________________________________
  Foods: ___________________________________

- **Is your child currently taking any medicines?**

  ____

Credit Card Information/Deductible Policy

All patients must present a credit card to be kept on file. This card will be used to charge **for copays, office tests or deductibles not covered by your insurance. Deductible balances are due immediately.** Your credit card information is encrypted in our system. Receipts are available upon request.

I read this statement and agree with this policy

Signed ___________________________________ **Print Name** _________________________________

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PATIENT PREFERRED CONTACT METHODS

Our office will contact you electronically to:

- Confirm appointments – **We can send you a text message 24 prior to your visit.**
- Notify you that your child is **due for vaccines** or physical exam.
- Notify you of **hours of operations** during holidays and vacations.
- Send you your **balances due**.

PLEASE FILL ONE FORM PER FAMILY

Patient(s) Name(s) ____

Primary Cell ______________________________ ☐ MOM ☐ DAD

Secondary Cell______________________________ ☐ MOM ☐ DAD

Primary Email______________________________ ☐ MOM ☐ DAD

Secondary Email ____________________________ ☐ MOM ☐ DAD

Home Number______________________________