David E. Simai M.D.

Board Certified Pediatrician

בס"ד
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

Patient Name: _____ **Gender:** _____ **DOB:** _____
Address: _____ **City/Zip:** _____ **State:** _____ **Phone:** _____

Father's Name: _____ **Social Security #:** _____ **DOB:** _____
□Email: _____ **Cell:** _____ **Occupation:** _____

Mother's Name: _____ **Maiden Name** _____ **SS#:**_____**DOB:** _____

Email: _____ **Cell:** _____**Occupation:** _____

Parents Marital Status: _____ **Emergency Contact:** _____ **Phone number:** _____

PLEASE ENTER **ALL INSURANCE POLICIES** THAT YOU HAVE - PRIVATE & MEDICAID/CHP

Primary Insurance: _____**Insurance ID:** _____ **Deductible: □yes □no**

Primary Card holder: _____ **Relationship to Patient:** _____ **DOB:** _____

If you have another insurance or additional PRIVATE insurance, YOU MUST PROVIDE the information here:

Secondary Insurance: _____ **Insurance ID:** _____ **Primary Holder:** _____

DIAGNOSIS AND TREATMENT I, authorize the staff of **Urgent One Medical Care P.C.** and those responsible for the care of the above named patient 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 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 and I agree 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 a change of Primary Care Provider (PCP) before being treated I accept full responsibility for obtaining such authorization. I also understand that balances resulting from my failure to obtain such authorization or change PCP in advance from my carrier are my responsibility. I also assume full financial responsibility for any medical treatment in case my insurance is currently or retroactively terminated for any reason, whether it is private or state funded insurance. 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 the 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 sign 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 ASSIGNMENT I, the undersigned, certify that the information given by me in applying for payment under TITLE XVIII (Medicaid) of the 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 the parent of this child. **I certify that the above insurance information is correct and I have given information on BOTH primary and secondary insurances I carry for myself/family members. It is my responsibility to ensure continuous insurance coverage and notify the office of ANY INSURANCE CHANGE prior to receiving medical treatment. If I have any copayments or deductibles I will keep an active credit card on file at all times. I do not need to be made aware when my deductibles will be charged, I will be made aware of the amount to be determined by my insurance company by the E.O.B. (Explanation of benefits).**

SIGNATURE_____ **Name Printed** _____ **DATE**_____

RELATIONSHIP OF PATIENT _____ **WITNESS TO SIGNATURE**_____

For Office Use Only: ☐ **Constant Contact** **Entered by** _____ ☐ **Scanned into chart**

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Patient History Form

David E. Simai, M.D.

Patients Name: _____ **Name of Previous Doctor:** _____

Birthplace_____
Birth weight_____
Birth length_____
Pregnancy problems_____
Delivery problems_____
Gestational age: _____
Nursery problems: _____

Family History:

Health of Father_____
Health of Mother_____
and Health of siblings _____
Family Diabetes _____
Family Allergies _____
Family Convulsions/seizures _____
Family high cholesterol _____
Family TB/Tuberculosis _____

Growth and Development:

Concerns with weight gain? _____
Concerns with height? _____
Behind in development? _____
School problems? _____
Sees counselor? _____
Problems sleeping? _____

Who may we thank for referring you?

_____

Problems eating? _____
In bed with a bottle? _____
Special diets? _____
Taking vitamins _____
Taking fluoride? _____
Had chickenpox? _____

Any problems with:

Ears _____
Sinuses _____
Throat _____
Lungs _____
Heart _____
Kidney/bladder _____
Bones/joints _____
Skin _____
Blood _____
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.

Missed appointment policy

If you miss your scheduled appointment for a physical more than once please be advised there will be a **$50 no show fee**.

I read these statements and agree with these policies

Signature _____ **Name Printed** _____ **Date** _____

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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 PREFERRED CONTACT METHODS

Our office will contact you by phone, email or text 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 financial **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_____