



# MacKoul Pediatrics of Cape Coral, FL

## Patient Information

**Full Name:** \_\_\_\_\_  
*Last* *First* *M.I.*

**Address:** \_\_\_\_\_  
*Street Address* *Apt./Unit #*

\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip Code*

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Social Security or Government ID #: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

Dentist: \_\_\_\_\_

Sibling(s) / Birthdate(s): \_\_\_\_\_

\_\_\_\_\_

## Parents / Legal Guardians

**Mother's Name:** \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

## Primary Insurance

**Insurance Company Name:** \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

## Referral Information

**How Did You Hear About Us?**  Friend/Family  Internet (Google)  Social Media  Other

**Other:** \_\_\_\_\_

**Emergency Contact Information**

Full Name: \_\_\_\_\_  
*Last* *First* *M.I.*

Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *State* *ZIP Code*

Primary Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

We are committed to providing your child with the best possible care. If have medical insurance we want to help you receive your maximum allowable benefits. To achieve this, we need your assistance and understanding of our payment policy

1. Our office submits all insurance claims for you. We must have your current insurance information, including a copy of your insurance card, the claims address, policy and group numbers.
2. Payment for services not covered by your insurance is due at the time of your visit
3. Payment is due at the time of the visit if you have third party insurance or a policy that does not send payment directly to our office
4. Copayments are due at the time of your visit
5. We accept cash, personal checks, Visa, Mastercard and Discover
6. Returned checks are subject to a \$30.00 fee
7. There is a \$50.00 charge for no show appointments.
8. If you have any questions about the above information please don't hesitate to ask us, we are here to help you.
9. I hereby authorize Mackoul Pediatrics staff to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents for claims filed by this practice

\$50.00 charge for all no show appointment Please Initial \_\_\_\_\_

IF PATIENT IS A MINOR: I \_\_\_\_\_ the \_\_\_\_\_ of \_\_\_\_\_ hereby personally accept financially responsibility for professional services by MacKoul Pediatrics for the aforementioned child

Signed: \_\_\_\_\_ Date \_\_\_\_\_

I/We hereby authorize my insurance benefits, to be paid directly to the physician and I/We hereby agree to be financially responsible for any amount not covered by insurance. I/We also authorize the physician to release any information required.

Patient/parent/guardian signature \_\_\_\_\_ date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

\_\_\_\_\_

## Family History

**Does/did the patient's mother have any of the following illnesses?**

- Diabetes     High Blood Pressure     Blood Disorders     Migraine Headache     None/Healthy  
 Asthma     Cancer     Kidney Problems     Other

**Does/did the patient's father have any of the following illnesses?**

- Diabetes     High Blood Pressure     Blood Disorders     Migraine Headache     None/Healthy  
 Asthma     Cancer     Kidney Problems     Other

**Does/did any of the patient's siblings have any of the following illnesses?**

- Diabetes     High Blood Pressure     Blood Disorders     Migraine Headache     None/Healthy  
 Asthma     Cancer     Kidney Problems     Other

**Does/did the patient's paternal grandfather have any of the following illnesses?**

- Diabetes     High Blood Pressure     Blood Disorders     Migraine Headache     None/Healthy  
 Asthma     Cancer     Kidney Problems     Other

**Does/did the patient's paternal grandmother have any of the following illnesses?**

- Diabetes     High Blood Pressure     Blood Disorders     Migraine Headache     None/Healthy  
 Asthma     Cancer     Kidney Problems     Other

**Does/did the patient's maternal grandfather have any of the following illnesses?**

- Diabetes     High Blood Pressure     Blood Disorders     Migraine Headache     None/Healthy  
 Asthma     Cancer     Kidney Problems     Other

**Does/did the patient's maternal grandmother have any of the following illnesses?**

- Diabetes     High Blood Pressure     Blood Disorders     Migraine Headache     None/Healthy  
 Asthma     Cancer     Kidney Problems     Other

## Social History

What type of home does your child live in?  
(apartment, duplex, single family home, etc)

\_\_\_\_\_

Is your home on city or well water?

\_\_\_\_\_

What type of heating system does your family use?

\_\_\_\_\_

Parents together?  yes  no

Does anyone in the family smoke?  yes  no

Are there any pets at home?  yes  no

Are there any guns in the home?  yes  no

Day care?  yes  no

## Please complete your health questionnaire to the best of your ability

### Ophthalmology

Any vision changes in the past year?  yes  no

Does your child wear glasses or contact lenses?  yes  no

Crossed or wandering eyes?  yes  no

Has your child ever had eye muscle surgery?  yes  no

Does your child have trouble reading or watching TV?  yes  no

### ENT/Respiratory

Has your child had frequent ear infections?  yes  no

Does your child have chronic ear drainage?  yes  no

Does your child have speech problems or speech delay?  yes  no

Does your child suffer from hearing loss?  yes  no

Does your child have chronic nasal congestion?  yes  no

Has your child ever had ear tubes put in?  yes  no

Does your child get frequent colds/upper respiratory infections?  yes  no

Does your child sneeze frequently or excessively?  yes  no

Does your child have seasonal runny nose or allergies?  yes  no

Does your child get frequent nose bleeds?  yes  no

Does your child get frequent sore throats or strep throat infections?  yes  no

Has your child has his/her tonsils removed?  yes  no

### Dental

Has your child ever had a cavity?  yes  no

Does your child have any bite (occlusion) defects?  yes  no

### Dermatology

Does your child have any birthmarks or moles?  yes  no

Does your child have acne?  yes  no

Does your child have a heavy tan or often sunburned?  yes  no

