DR. REMI ADESOJI, PEDIATRICIAN
PROGRESSIVE PHYSICIANS PRACTICE, PLLC.
8412 AIRWAYS BLVD, SOUTHAVEN, MS 38671
PHONE: (662) 536-2100 FAX: (662) 536-2211

CHILD:
Last Name: ____________ First Name: ____________ MI: ________

Address: ____________ City: ____________ State: ______ Zip: ______

Soc Sec Number: ____________ Date of Birth: ____________ Sex: ________

Telephone Number: ____________ **Email:** ____________

FATHER:
Last Name: ____________ First Name: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Soc Sec Number: ____________ Date of Birth: ____________

Employer: ____________ Work Number: ____________

MOTHER:
Last Name: ____________ First Name: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Soc Sec Number: ____________ Date of Birth: ____________

Employer: ____________ Work Number: ____________

EMERGENCY CONTACT: (other than Parent)
Name: ____________ Relationship to Child: ____________ Telephone: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

RESPONSIBLE PARTY:
Name: ____________ Relationship to Child: ____________

INSURANCE:
1st Company Name: ____________ ID #: ____________ Group #: ____________

Policy Holder: ____________ Relationship to Child: ____________

2nd Company Name: ____________ ID #: ____________ Group #: ____________

Policy Holder: ____________ Relationship to Child: ____________

BENEFITS AUTHORIZATION:
I authorize treatment of the patient named above and agree to pay all fees and charges billed by Progressive Physicians Practice. I request that payment of authorized Insurance Company or third party insurance be made to Progressive Physicians Practice or one of its physicians if assignment is accepted in which case agree to pay any deductible, co-payment or disallowed charges. If assignment is not accepted I agree to pay the entire amount due. I authorized any holder of medical information about me to be released to the Health Care Financing Administration and its agents, the Division of Medicaid and their Fiscal Agent or any third party insurance, any information needed to determine these benefits. If you default on any payment you will be responsible for any COLLECTION AGENCY CHARGES.

Parent or Guardian Signature: ____________________ **Date:** ____________

Initial History Questionnaire

Name ______

ID NUMBER ______

FORM COMPLETED BY ______ DATE COMPLETED ______

BIRTH DATE ______ AGE ______ M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. ______

If mother and father are not living together or if child does not live with parents, what is the child's custody status? ______

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? ______

Birth History

Birth weight ______

Was the baby born at term? ______ Early? ______ Late? ______

If early, how many weeks' gestation? ______

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain ______

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What ______ When ______

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? ______

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain ______

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ______

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain ______

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain ______

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain ______

Has your child had any surgery? ☐ Yes ☐ No Explain ______

Has your child ever been hospitalized? ☐ Yes ☐ No Explain ______

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain ______

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain ______

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain ______

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain ______

If your child is in school:

How is his/her behavior in school? ______

Has he/she failed or repeated a grade in school? ______

How is he/she doing in academic subjects? ______

Is he/she in special or resource classes? ______

Family History

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	☐ Yes	☐ No	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	Who ______	Comments ______
Asthma	☐ Yes	☐ No	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	Who ______	Comments ______
Heart disease (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
High cholesterol	☐ Yes	☐ No	Who ______	Comments ______
Anemia	☐ Yes	☐ No	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	Who ______	Comments ______
Liver disease	☐ Yes	☐ No	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	Who ______	Comments ______
Diabetes (before 50 years old)	☐ Yes	☐ No	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	Who ______	Comments ______
Mental illness	☐ Yes	☐ No	Who ______	Comments ______
Mental retardation	☐ Yes	☐ No	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who ______	Comments ______

Additional family history ______________________________

____

____

Past History

Does your child have, or has he/she ever had:

Condition	Yes	No	When / Explain
Chickenpox	☐ Yes	☐ No	When ______
Frequent ear infections	☐ Yes	☐ No	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	Explain ______
Nasal allergies	☐ Yes	☐ No	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	Explain ______
Blood transfusion	☐ Yes	☐ No	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	Explain ______
Bladder or kidney infection	☐ Yes	☐ No	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain ______
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When ______
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain ______
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain ______
Frequent headaches	☐ Yes	☐ No	Explain ______
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain ______
Diabetes	☐ Yes	☐ No	Explain ______
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain ______
Any other significant problem	☐ Yes	☐ No	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	Explain ______

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individual circumstances, may be appropriate.

PROGRESSIE PHYSICIAN PRACTICE, PLLC
CERTIFIED PEDIATRICIAN
DR. REMI ADESOJI

This form is to give us permission to see your child when brought in by other family members or friends.
Please list the persons that you give permission to bring your Child/children to the physician.

NAME/RELATIONSHIP:

1. ____

2. ____

3. ____

Parents Signature ______________________________

PROGRESSIVE PHYSICIANS PRACTICE, PLLC
~~7900~~ 8412 AIRWAYS BLVD, BLDG C, SUITE 5B
SOUTHAVEN, MS 38671

TO: Patient with Medicaid Coverage

I ______________________ certify that ______________________
(Name of the patient guardian) (Name of patient)

Has no other medical insurance coverage including Commercial, Blue Cross/Blue Shield or other insurance plans.

Signed ______________________ Date ______________________
(Signature of patient)

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT OF RECEIPT

I, ______________________________ have received a copy of Progressive Physicians Practice's notice of Privacy Practices and I have been given an opportunity to ask questions.

____
Signature of Patient/Parent

____
Date

Progressive Physicians Practice

FINANCIAL AGREEMENT

The undersigned severally agrees, whether signing as a patient or otherwise, that in consideration of the services rendered to the patient, payment of the account is guaranteed by the undersigned. While any insurance or other protection related to the account may be hereby assigned to and payable directly to us, the undersigned clearly understands that the obligation to pay the bill is primarily on the patient and account, any part of the account not so paid by insurance is nevertheless owing and payable. In case of default of payment, and if this account should be placed in the hands of a collector or an attorney for collection, all collection fees, attorney fees, cost and other expenses will be paid by the undersigned.

Patient's or Guarantor's Signature ______________________________

Guarantor's Signature ______________________________________

Date ________________________

PROGRESSIVE PHYSICIANS PRACTICE
AUTHORIZATION FOR DISCLOSER OF HEALTH INFORMATION

Patient Name:____
Date of Birth:______________________________ Phone:______________________
Address:____
City:______________________ State:________________ Zip:___________________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make this discloser:

Name of Hospital, Clinic, and/or Facility:

____
Address:____
City:_________________________ State:_________________ Zip:________________
Phone:__________________________ Fax:_______________________________

3. The type and amount of information to be used or disclosed is as follows: (Includes dates where appropriate.)

____ Compare health records
____ Physical exam
____ Immunization records
____ Other (please specify:_______________________________________
____ Lab results/ X-ray reports
____ Consultation reports

4. I understand that the information in my health record may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS) or human Immunodeficiciency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization

PROGRESSIVE PHYSICIANS PRACTICE, PLLC

8412 AIRWAYS BLVD
SOUTHAVEN, MS 38671
662-536-2100 PHONE
662-536-2211 FAX

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department at PROGRESSIVE PHYSICIANS PRACTICE 8412 AIRWAYS BLVD. SOUTHAVEN MS. 38671. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy, unless otherwise revoked; this authorization will expire in 60 days.

____
PATIENT SIGNATURE (OR LEGAL REPRESENTATIVE)

____
DATE