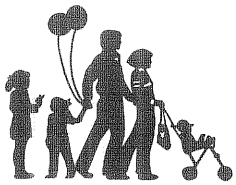


Clermont Pediatrics, P.A.

861 Oakley Seaver Dr.
Clermont, FL 34711
Tel.: (352) 394-7125
Fax: (352) 394-2584

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____ AGE: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: (____) _____ M/F _____ Social Security #: _____
MOTHER'S NAME: _____ SS #: _____ CELL PH.: (____) _____
ADDRESS AND PHONE (if different) _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____
FATHER'S NAME: _____ SS #: _____ CELL PH.: (____) _____
ADDRESS AND PHONE (if different) _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____
REFERRED BY: _____ PHONE: (____) _____

IN CASE OF EMERGENCY
CLOSEST RELATIVE NOT LIVING WITH YOU: _____ PHONE: (____) _____

PERSON RESPONSIBLE FOR BILL

LEGAL NAME: _____ RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
DRIVER LICENSE #: _____ STATE ISSUED: _____
ADDRESS: _____
MAILING ADDRESS (if different): _____
PHONE: HOME (____) _____ WORK (____) _____ CELL (____) _____
E-MAIL ADDRESS: _____ EMPLOYER: _____

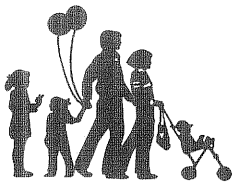
INSURANCE COMPANY INFORMATION

Insurance: _____ I.D. #_____ Group Name or #_____
Address: _____ Phone: (____) _____
Policy Holder's Name: _____ Date of Birth: _____

Secondary Insurance: _____ I.D. #_____ Group Name or #_____
Address: _____ Phone: (____) _____
Policy Holder's Name: _____ Date of Birth: _____

PLEASE ANSWER THE FOLLOWING

Have you or anyone in your immediate family been a patient in our office before?____ yes ____ no. If yes, please list:
Name: _____ Relationship: _____ When? _____
Has your child been seen in the hospital by our physicians?_____ yes _____ no.



CLERMONT PEDIATRICS, P.A.
INITIAL PEDIATRIC HISTORY FORM

Child's Name: _____ **Birthday:** _____ **Today's date** _____

A. Birth History

1. Birthplace _____
2. Was pregnancy normal? _____
3. Was delivery normal? _____
4. Was baby full term? _____
5. Birth weight _____ length _____
6. Any nursery problems? _____

B. Growth and Development

1. Ages when first:
   Sat _____ Crawled _____
   Rolled _____ Walked _____
   Talked _____ Toilet trained _____
2. School history:
   Year in school _____ Nursery _____
   Grades averaged _____
   School name _____
   School problems? _____
   Attends special school or classes? _____
   _____
   Discipline or behavior problems? _____
   _____
   Ever seen by a psychologist, speech therapist or special teachers? _____

C. Past Medical History

1. Any problems with:
   Sleeping? _____ Bedwetting? _____
   Weight/Height? _____ Nail biting? _____
   Nightmares? _____
2. Diet:
   Nursed or bottle fed? _____
   Any colic problems? _____
   Used special diets? _____
3. Contagious diseases (what age?)
   Chicken pox _____
   Scarlet fever _____
   Any other? _____
4. Was your child ever diagnosed with any of the following? (what age?)
   Seizures _____ Asthma _____
   Bronchitis _____ Pneumonia _____
   Ear infections _____
   Any other? _____
5. Medications: Does your child take any medications now?
   _____
   _____

D. Hospitalizations

(When, where, why?) _____
_____
_____

E. Surgery

(When, where, why?) _____
_____

F. Serious Injuries

(When, where?) _____
_____
_____

G. Allergic Reactions

(Drugs, immunizations, asthma, hives, eczema, etc.) _____
_____

H. Family History

1. Father: Living _____ Age: _____ Health: _____
2. Mother: Living _____ Age: _____ Health: _____
3. Brother/Sisters: _____ How many? _____
   Ages _____ Healthy? _____
4. Any family history of:
   Diabetes _____ Allergies _____ Convulsions _____
   Heart disease _____ TB _____ Cancer _____
   Other? _____

I. General Information

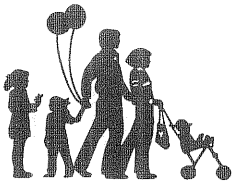
Has your child had any unusual problems with the following?
Head _____
Eyes _____
Ears/Nose/Throat _____
Chest/Heart/Lungs _____
Stomach _____
Kidneys _____
Bladder _____
Bones/Muscles/Joints _____
Skin _____
Blood _____

J. Immunizations

Did you bring a record of immunizations of your Child?
_____ Yes _____ No

K. Any special comments about your child?

_____
_____
_____
_____
_____



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FINANCIAL POLICY

Thank you for choosing us as your child's health care provider. We are committed to providing your child comprehensive Pediatric care. Please understand that payment of your child's bill is considered part of their treatment. The following is a statement of our financial policy. We require you to read and sign prior to any treatment. **ALL PARENTS MUST COMPLETE ALL PAPERWORK BEFORE THEIR CHILD IS SEEN.**

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR CREDIT CARDS. If a check is returned to us for any reason, your child's account will be charged the amount of the check plus a $25.00 returned check fee.

USUAL & CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

There is a $25.00 fee for all after hours telephone calls and a $25.00 fee for appointments not cancelled 24 hours prior to your appointment time.

WE CANNOT BILL YOUR INSURANCE COMPANY UNLESS YOU GIVE US A COPY OF YOUR CHILD'S INSURANCE CARD. Without a copy of the card, you will be responsible for 100% of the charges on that date of service. We will file to your insurance company, however, if you must pay a percentage of the bill, it must be paid at the time of service. **All copays are due at the time of service.**

The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable by your insurance policy.

If you are unable to pay the balance in full, we can arrange a payment plan. If the balance is 90 days past due and/or you default on your payment plan, the account will be forwarded to a collection agency. You will be responsible for any fees incurred from the collection agency and/or legal services hired by Clermont Pediatrics, P.A. Furthermore, your child will be discharged from the practice.

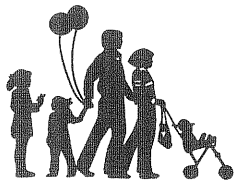
In the event that your insurance changes, it is your responsibility to notify us as we may be non-participating providers. Failure to do so will result in you being responsible for all charges incurred. It is not the responsibility of Clermont Pediatrics, P.A. to ensure we are providers. Our main concern is the health of our patients.

Regarding HMO, Managed Care and Medicaid plans, you are responsible for making sure that our practice and/or doctors are listed as your child's Primary Care Physician. Failure to do so will result in you being responsible for all charges incurred.

We provide lab work as a professional courtesy. You are responsible for providing us with the correct laboratory in which to send lab work. If your child's lab work is sent to an incorrect laboratory, you will be responsible for all charges incurred.

I have read and fully understand Clermont Pediatrics, P.A. Financial Policy.

Parent's name (print)	Child's name (print)
X Parent's signature	Date



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CONSENT FOR TREATMENT
PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Clermont Pediatrics, PA for the purpose of diagnosing or providing treatment to me/my child, obtaining payment for my/my child's health care bills or to conduct health care operations of Clermont Pediatrics, PA.

I have the right to revoke this consent, in writing, at any time, except to the extent that Clermont Pediatrics, PA has taken action in reliance on this consent.

My/my child's "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my/my child's past, present or future physical or mental health or condition and identifies me/my child, or there is a reasonable basis to believe the information may identify me/my child.

CLERMONT PEDIATRICS, PA has an established privacy policy which is displayed in this office and I can request a printed copy of this policy.

X _____ _____

Signature of Patient or Parent / Guardian | Name of Patient

_____ _____

Relationship to Patient | Date

Clermont Pediatrics, P.A.

861 Oakley Seaver Dr.
Clermont, FL 34711
Tel.: (352) 394-7125
Fax: (352) 394-2584

ASSIGNMENT OF BENEFITS FORM

Date: _____

Patient: _____ Parent/Guardian: _____

Claim Group: _____

SS #/ID #: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: Clermont Pediatrics, P.A.
1755 East Highway 50, Suite A
Clermont, FL 34711

Or

If my current policy prohibits direct payment to a doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

1755 East Highway 50, Suite A
Clermont, FL 34711

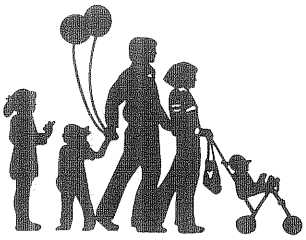
For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signed: X _____ Relationship to Patient: _____

Date: _____ Witness: _____



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AUTHORIZATION FOR MEDICAL CARE

I (WE) _____ authorize
PRINT NAME OF LEGAL GUARDIAN(S)

Clermont Pediatrics, P.A. and it's personnel to deliver medical services to

my child _____ .
PRINT CHILD'S NAME AND DATE OF BIRTH

I (WE) authorize the following people to bring my child in for treatment: (This form must be filled out in order for anyone other than parents listed on patient information form to bring in your child.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X _____ _____
SIGNATURE OF LEGAL GUARDIAN DATE

Relationship to patient: _____

_____ _____
WITNESS (PRINT/SIGN) DATE