NEW PATIENT INFORMATION			
Patient Last Name, First Name	**Birth Date**	**Male** ☐ **Female** ☐	**Social Security #**
Street Address	**Apt#**	**Home Phone**	
City	**State**	**Zip Code**	**E-mail Address**

PARENT/GUARDIAN INFORMATION		
Mother's Name	**Birth Date**	**Social Security #**
Cell Phone	**Work Phone**	**Place of Employment/Occupation**
Father's Name	**Birth Date**	**Social Security #**
Cell Phone	**Work Phone**	**Place of Employment/Occupation**

EMERGENCY CONTACT INFORMATION			
Name	**Home Phone**	**Cell Phone**	**Relationship**

INSURANCE INFORMATION	
Insurance Name	**Insurance Phone**
Policy Holder Name (If Medicaid write Self)	**Policy Holder Relationship to Patient (please Circle)** Parent / Self /Other: ________________
ID#/Policy #	**Group#**
Insurance Address	**City and State**

Who if anyone other than parent or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in ____________ without your presence and making medical decisions for his or her treatment.	☐ N/A	☐ Yes the following individuals
Name	**Relationship**	
Name	**Relationship**	
Name	**Relationship**	

I certify that the above information is correct to the best of my knowledge. I release to Pediatric and Family Care, it's employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individuals(s) pertaining to my child's care and medical records.

____ ____________________

Patient/Legal Guardian/Guarantor: Date:

*Please fill out ALL fields

Patient History

Patient's Name ______________________________ Birth Date: ______________ Date: ________________

Name all persons living in the patient's home at the present time

Name	Age	Relationship	Medical Concerns

Languages Spoken:

☐English ☐Spanish ☐Portuguese ☐French ☐Creole ☐Urdu ☐Chinese

☐Other[s] (most fluent first): ____________________

Ethnicity: ☐ Hispanic ☐ Prefer not to answer ☐ Other: ____________________

Race:

☐Asian ☐American/Indian/Alaskan Native ☐Black ☐White ☐Hawaiian Native ☐Pacific Islander ☐Prefer not to answer

Allergies: (list type of reaction)

☐ Medication:

____

☐Food

____

☐ Other[s]: ____

Birth History

Where was the patient born? (Hospital and city) ____

Birth Wt: ________________ Birth Ht: ____________ Gestational Age (how many weeks?): _______________

☐ Cesarean Section ☐ NSVD (vaginal delivery)

☐ Problems/complications (list):

____

____

____

Family Medical History (Check and circle all that apply)

☐ Heart Disease: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis

☐ Asthma: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis

☐ Cancer: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis

Type of Cancer: ____

☐ Diabetes: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis

☐ Ovarian Cyst: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis

☐ Thyroid Disease: Mom Dad MaternalGrandma MaternalGrandpa PaternalGm PaternalGf Aunt Uncle Bro Sis

Type of Thyroid Disease: ____

☐ Other[s] (list): ____

*Please fill out ALL fields

Patient's Past Medical History

Has the patient ever had any of the following: (check as many as apply)

- ☐ ADD/ADHD
- ☐ Allergic Rhinitis (allergies)
- ☐ Anemia, Hemophilia
- ☐ Asthma
- ☐ Atopic Dermatitis (Eczema)
- ☐ Autism
- ☐ Bronchitis/Wheezing
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Frequent Ear Infections
- ☐ Hay Fever / Allergy
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Pneumonia
- ☐ Seizures (Epilepsy)
- ☐ Sinusitis
- ☐ Varicella(Chickenpox) Date: ________________
- ☐ Other[s]: (list) ____________________________

____

I would like to discuss the following concerns:

____

____

____

Past Surgical History

☐Tonsils Removed ☐Adenoids Removed ☐Inguinal Hernia Repair ☐Ear Tube Placement ☐Heart Surgery ________________________ ☐Broken Bone (surgical repair) ___________________________

Other[s]: ____

Hospitalizations: ☐ None ☐ Yes

Reason (if any): ____ Date[s]: _____________

Medications

☐Daily Medications or Vitamins (include dosage):

____

____

☐Medications taken today: ____

Social History:

☐Daycare ☐School (Grade: __________)

☐Pets: Dog[s]: _________ Cat[s]: _________ Other[s]: ___________________________________

☐Smoker[s] in home (includes inside and outside): ____

Patient's Habits (if >13 yrs. old)

☐ Non-Smoker

☐ Smoker: Tobacco ☐Other: ____

Pharmacy** **(Very Important! This is where your prescriptions will be electronically sent in the near future. We need at least the phone number for the pharmacy of your preference.)**

☐CVS ☐Walgreens ☐Publix ☐Target ☐Wal-Mart ☐Other: _____________________

Phone Number (w/ area code): ____

Address: ____

FINANCIAL POLICY

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to PEDIATRICS AND FAMILY CARE I understand that I am financially responsible for all services rendered and for the following reasons:

1) I have given incorrect/invalid insurance information
2) Expenses are not covered by my insurance company
3) I have not met my deductible/coinsurance
4) The services rendered are deemed medically unnecessary by my insurance company.

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

A returned check penalty fee of $25 will be charged to a patient's account for any check dishonored by the drawee bank. Fee will be waived if the check was returned in error, provided with supporting documentation. The returned check and penalty fee must be paid by cash, credit card or money order. If a returned check was used to pay for more than one patient, each patient will be assessed the $25 returned check fee. Payments made by a returned check are reversed from the patient's account, leaving the balance due and payable immediately.

All forms to be signed by physician will be a $15 fee for each form, with the exclusion of FMLA forms, which are $25.00. Duplicate forms for physicals and shot records are $5 each.

Our "No Show" office fee is $25.00 and after (3) three "No Shows" you will be dismissed from the practice.

HIPAA COMPLIANCE STATEMENT

At Pediatrics And Family Care, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to obtain a copy of your chart for a fee and tell us not to release your information.

USE AND DISCLOSURE OF PHI

Our practice may use and disclose PHI for the purposes of treatment, payment and business operations. The following categories describe the different ways in which we may use and disclose PHI for these purposes: Treatment, Payment, Health Care Operations, Release or Sharing of Information, The Rights of Minors and Personal Representatives, Release of Information to Business Associates, Release of Information Required by Law, Research Purposes and Marketing Purposes.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding the PHI that we maintain about your child or you: Requesting Restrictions on PHI, Inspection and Copies of PHI, Amendment of PHI, Accounting of Disclosures, Right to a Paper Copy of This Notice, Right to File a Complaint, Right to Provide an Authorization of Other Uses and Disclosures

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission. For more information, concerns or would like additional information, you may contact the office manager at (407) 286-3653.

____

Name of Patient

____

Signature of Patient /Patient Representative

____________________________ ____________________________

Relationship of Patient Date

Pediatrics and Family Care

Financial responsibility agreement for:
Deductible/Coinsurance Responsibility
Insurance Verification
Pending Insurance
Self-pay Patients

Today's date: ______/______/________

Patient Name: _________________________________ Date of Birth: ____/____/______

□ **Self-pay:** I understand that if I am a self-pay, or if Pediatrics and Family Care does not accept my insurance, I will be charged up front the rate of an office visit. This payment will not include the rate of an extended visit or any test that need to be performed. (Please stop at end of service for additional payment). If unable to confirm level of service or all test or supplies used, I may receive an additional payment request by mail.

□ **Co-Insurance/Deductible:** I understand that I will be charged up front for the estimated insurance contracted allowance rate of an office visit. This payment will not include the rate of extended visit or any tests that need to be performed. (Please stop at the end of service for additional payment.) If we are unable at the time of check out to confirm level of service or all test or supplies used, I may received an additional payment request by mail depending on my insurance deductible or allowance.

□ **Verification:** I understand that my eligibility for coverage by **_____________________** insurance cannot be confirmed at this time. I wish to receive medical service from Pediatrics and Family Care. If it is determined that I am not eligible for coverage, I will be responsible for the payment of all services provided.

□ **Pending Insurance:** I understand that my insurance is pending and I will pay for today's service. If vaccinations are required, I will pay $15.00 for each vaccine. If my insurance can be provided at a later date that encompasses this visit, only the office visit and procedures can be billed. The vaccines given were state shots and cannot be sent to my insurance company.

____

Patient/Legal Guardian and/or Responsible Party Signature

Medical Record Release Authorization

I, ___________________________________ (**Parent/Legal Guardian**), hereby authorize **Pediatrics and Family Care** to:

Release Copies of the medical records of my child:

____

(**Patient name, DOB, and SSN**)

TO: **PEDIATRICS AND FAMILY CARE**	FROM:
Address: **5626 CURRY FORD RD**	Address:
City, St, Zip Code **ORLANDO, FL 32822**	City, St, Zip Code
Office: **407-286-3653**	Office:
Fax: **407-286-4739**	Fax:

*THERE IS A NOMINAL COPYING FEE OF $1.00 PER PAGE, UNLESS REQUEST WILL BE SENT TO ANOTHER DOCTOR'S OFFICE.

THE FOLLOWING:

- ☐ Hospital records including Hx & Phys and Discharge Summaries from the dates: ____________ to ___________
- ☐ Emergency Room Notes from the period: ____________ to ___________
- ☐ Diagnostic Tests and Labs
- ☐ Immunization Records
- ☐ Office Notes from this period: _____________ to _____________
- ☐ Complete Medical Record

PURPOSE OF DISCLOSURE:

- ☐ Referral to Specialist
- ☐ Change of Physician
- ☐ Continuing Care
- ☐ Insurance
- ☐ Personal
- ☐ Legal Investigation
- ☐ Disability Determination/SSI
- ☐ Other, please specify:

INFORMATION TO BE EXCLUDED, NOT RELEASED:

- ☐ Mental Health Records
- ☐ Sexual Assault/ Victimization Records
- ☐ HIV Testing
- ☐ Drug Alcohol Treatment
- ☐ Other, please specify: _______________________________________

I hereby authorize disclosure of the health information for the above name patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_________________________________	______________________	______________________
SIGNATURE OF PARENT/LEGAL GUARDIAN	RELATION TO PATIENT	DATE