NEW PATIENT INFORMATION

Patient Last Name, First Name_____ DOB_____

Male____Female____ Phone_____

Address _____State ____Zip Code _____

Languages Spoken: English____ Spanish____ Other(s)_____

Ethnicity: Hispanic _____ Non-Hispanic_____ Other_____

Race:
Asian ____American/Alaskan Native ___ Black ___ White ____Hawaii Native___ Prefer not to answer ____

PATIENT/GUARDIAN INFORMATION

Mother's/Guardian Name _____Birth Date _____

Phone_____ E-mail Address**(Required)** _____

Occupation _____ S.S#_____

Father's/Guardian Name_____ Birth Date _____

Phone _____ E-mail Address(**Required)** _____

Occupation _____ S.S# _____

EMERGENCY CONTACT INFORMATION

Name _____Home Phone_____ Cell Phone _____

Relationship to patient_____

INSURANCE INFORMATION

Insurance Name _____Policy Holder Name (If Medicaid write self) _____

Policy Holder Relationship to the Patient: parent /self /other: _____Insurance Phone _____

ID/Policy/Subscriber # _____Group # _____

Insurance Address_____City_____State_____

Who if anyone other than parent or legal guardian has permission to access your child's medical record and obtain results for labs tests including bringing your child in the office without your presence and making medical decisions for his or her treatment.

____N/A **____Yes the following individuals**

Name _____ Relationship to the Patient_____

Name _____ Relationship to the Patient_____

I certify that above information is correct to the best of my knowledge. I release Tots &Teens Pediatrics, its employees and clinic from all liability for any adverse results caused by my authority and discuss with the above individual (s) pertaining to my child's care and medical records.

Parent/Legal Guardian: _____ Date:_____

PHARMACY

We will submit prescriptions electronically to the pharmacy of your choice. Please specify below which pharmacy you would like us to send the prescriptions to. Please make sure to give us all the requested information.

Pharmacy Name:_____
Phone Number: _____
Address: _____ **City**:_____**Zip**:_____

I hereby authorize Tots & Teens Pediatrics to obtain my childs' /my RX history.

Signature: _____ Date:_____

PLEASE FILL OUT ALL FIELDS

MEDICAL HISTORY

Has the patient ever had any 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): _____

I would like to discuss the following concerns:

_____

ALLERGIES: (list type of reaction)

Medication: _____

Food: _____

Other(s)_____

PAST SURGICAL HISTORY (please indicate date if possible)

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:

Current medications or vitamins (include dosage if possible):

_____

Medication taken today: _____

BIRTH HISTORY:

Place of Birth: _____ Type of Delivery: _____

Full Term? [ ] Yes [ ] No Gestational age:_____ Birth Weight: _____ lbs. _____ oz. Birth Length: _____ in.

Number of pregnancies: _____ Number of Miscarriages: _____

FAMILY MEDICAL HISTORY (**include age and medical conditions**)

Mother: _____

Father: _____

Siblings (brothers/sisters): _____

Grandparents (maternal): _____

Grandparents (paternal): _____

Other(s): _____

SOCIAL HISTORY:

Pets ____

Daycare _____ (after-school or other)

Patient lives with _____

Child's School: _____ Grade: _____

NUTRITION HISTORY: (Answer if applicable)

Is the child breast fed or on formula? _____ Please specify which formula: _____

Any feeding problems? _____

Current medications: _____

DEVELOPMENTAL HISTORY: (Answer If Applicable)

Roll over by 4 months: [ ] Yes [ ] No _____

Sit up by 6 months: [ ] Yes [ ] No _____

Say several words by 1 year: [ ] Yes [ ] No _____

HAS YOUR CHILD ENGAGED IN ANY OF THE FOLLOWING: (If Applicable)

[ ] Drinking Alcohol [ ] Smoking [ ] Drugs [ ]Sexual Activity

SAFETY & ACCIDENT PREVENTION: **Please answer yes or no**

Are all medicines, cleaning products, and other dangerous substances locked up and kept out of reach? [ ] Yes [ ] No

Is your home equipped with smoke alarms? [ ] Yes [ ] No

Do you have safety plugs in unused wall sockets? [ ] Yes [ ] No

Do you have the telephone number of Poison Control? [ ] Yes [ ] No **Poison Control Hotline 1-800-222-1222**

Does your child know how to swim? [ ] Yes [ ] No

Does your child always use a car seat or safety belt? [ ] Yes [ ] No

Have you had first aid training? [ ] Yes [ ] No

Authorization to Obtain, Release or Copy Protected Health Information

Patient Name: _____ D.O.B: _____ Home Phone_____

Address_____
City State Zip Code

By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.

THIS AUTHORIZATION PERMITS:

Provider Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ Sate: _____Zip Code: _____

TO OBTAIN FROM:_____
TO DISCLOSE TO: _____ **TOTS&TEENS PEDIATRICS**
4691 OLD CANOE CREEK RD ST. CLOUD FL 34769
TEL: (407)-593-2883 FAX (407)-593-2884

The following information:

- Hospital records including *History & Physicals and discharge summaries*
- Emergency Room Notes
- Diagnostic Tests and Labs
- Immunization Record
- Office Notes
- Complete Medical Record From the dates: _____to _____

PURPOSE OF THE DISCLOSURE:

___ Referral to Specialist
___ Change Physician ___ Insurance ___ Other: _____

INFORMATION TO BE EXCLUDED, NOT RELEASED:

___ Mental Health Records ___ Drug alcohol Treatment
___ HIV Testing ___ Sexual Assault/Victimization Records
___ Other: _____

I hereby authorize **disclosure of the health information** for the above named 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 the Patient Date

Notice of Privacy Practices: This notice describes how health information about your child (as a patient of this practice) may be used and disclosed and how you have access to this information. Please review this notice carefully.

Our Commitment to Privacy. Tots &Teens Pediatrics is dedicated to maintaining the privacy of its patients' protected health information. We are required by the law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. We reserve the right to amend, our Notice. By federal and state law we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Use and Disclosure of PHI. Our practice may use and disclose protected health information (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
- The Right of Minors and Personal representatives
- Release of Information to Business Associates
- Release of Information Required by Law
- Research Purposes
- 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

If you have any questions regarding this notice or our health information privacy policies, please contact our staff at 407-593-2883.

I have read this Office's Notice Practices, which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____	_____	_____
Parent/Guardian Signature	**Patient Name**	**Date**

FINANCIAL AND INSURANCE POLICIES

By signing below, you are indicating that you have read, understand, and agree to all the policies contained on this page:

I hereby authorize direct payment of medical benefits to Tots & Teens Pediatrics for services by the physicians or the organization; I understand that I am responsible for any balances not covered by the insurance.

Claims not paid within a timely manner (60) days by the insurance company, become my responsibility.

Full Payment for all co-pays, deductible and non-covered services are expected at the time of your appointment. All other payment arrangements must be made with our Office Manager 24 hours prior to the appointment time.

A returned check penalty fee of $ 25 will be charged to a patient's account for any check dishonored by the drawee bank. This 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 returned check are reversed from the patient's account, leaving the balance due and payable immediately.

Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered test, procedures or visits to third party providers are to be directed to your insurance carrier.

I hereby authorize Tots &Teens Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

I Certify that the information given by the applying for payment under title XVII of the Social Security administration or the intermediaries of carrier's any information about myself to release to the Social Security administration or the assign, transfer and set the over the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under the insurance policy with any and all insurance companies, I permit a copy of this authorization to be used in place of the original.

Patient Name_____

_____ _____ _____

Parent/Guardian Signature Print Name of Parent/Legal Guardian Date

LEAD RISK ASSESSMENT QUESTIONNAIRE

Patient Name _____ Date _____
Completed by _____ Relation _____

1. Does your child live in or regularly visit an old house built before 1960? **Y N**
2. Was your child's daycare center, preschool, or baby-sitter's home built before 1960? **Y N**
3. Does your child live in a house built before 1960 with recent, on-going, or planned renovation or remodeling? **Y N**
4. Does your home contain old furniture or painted wood that your child can chew (crib, banister, windowsill) **Y N**
5. Does your child eat paint chips, dirt, or old crayons? **Y N**
6. Does your child frequently come in contact with a person who works with lead? (i.e. in construction; in welding; with pottery; fishing weights; casting ammunition; toy soldiers; stained glass; and refinishing furniture) **Y N**
7. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead or industrial pollution? **Y N**
8. Do you give your child any home folk remedies that may contain lead? (Examples: Alacon, Alkohl, Azarcon, Bali Goli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, and Rueda) **Y N**
9. Does your home's plumbing have lead pipes or copper with lead solder joints? Y N
10. Have any of your children or their playmates been followed up or treaded for lead poising? Y N

TB RISK ASSESSMENT

1. Has your child been in contact with a person confirmed or suspected of having Tuberculosis? **Y N**
2. a. Has your child ever had a Tuberculosis test done in the past? **Y N**
   b. If yes, was the test positive? **Y N**

3. Has your child moved from or traveled to Asia, Africa, Latin America or the Middle East? **Y N**
4. Does your child live with a person who immigrated from or travels to Asia, Africa, Latin America or the Middle East? **Y N**
5. Did your child move from a large city? **Y N**
6. In the last 3 months has your child or anyone you know had any of the following: chronic cough, coughing blood, night sweats, or weight loss? **Y N**
7. Is your child exposed to a person threat is: HIV infected, immunocompromised , homeless, resident of a nursing home, institutionalized, incarcerated or was in prison, a drug dealer, or a migrant farm worker? **Y N**