ATTENTION: NEW PATIENTS

Welcome to **PALMETTO Pediatrics**! As you may already know, Dr. Parikh, Dr. Kondabala, and Dr. Rau are our physician providers. As a new patient with us, there are some forms for you to fill out for your child. We also need the following documents.

1. Parent/Guardian ID (Driver's License, Identification card, etc.)
2. Child's Social Security card
3. Child's Insurance card
4. Child's vaccine record (If it is out of state)
5. Previous medical records

Once again, Thank You for Choosing Palmetto Pediatrics as your child's Medical Home!!!

PATIENT INFORMATION (PLEASE PRINT)

TODAYS DATE_____

Name: _____ D.O.B. _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE ( )_____ CELL( )_____ WORK( )_____

S.S. # _____ SEX _____ AGE_____

RESPONSIBLE PARTY

Name: _____ D.O.B. _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

Home Phone ( )_____ Cell Phone ( )_____ Work Phone( )_____

Marital Status: S/M/W/D S.S. # _____ LIC # _____

INSURANCE INFORMATION

Primary Ins. Name _____
Ins. Address _____
_____

Name of Insured _____
Insured's I.D. # _____
Group # _____ D.O.B. _____
Relationship to Patient _____
Employer Name _____
Emplover Address

Secondary Ins. Name _____
Ins. Address _____
_____

Name of Insured _____
Insured's I.D. # _____
Group # _____ D.O.B. _____
Relationship to Patient _____
Employer Name _____
Emplover Address

In case of Emergency, who should be notified? _____ **Phone** _____
Pharmacy of choice: _____ **Phone** _____
EMAIL ADDRESS FOR WEB PORTAL : _____

I authorize the release of medical and personal information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and to help obtaining Medicaid HMO enrollment. I also authorize payment of medical benefits to the physician.

Parent Signature: _____ **Date:** _____

In order to establish optimal relations and avoid misunderstanding and confusion, regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in form of cash or credit card. In the event of hospitalization or major procedures, our office may file with the appropriated insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Parent Signature: _____ **Date:** _____

I authorize following persons to bring my child for medical care & I authorize them access to medical records.

Name	SSN
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Parent Signature: _____ **Date:** _____

CHILD HEALTH HISTORY
(BIRTH THROUGH 10 YEARS)

PATIENT NAME:	☐ Male ☐ Female	DOB :

ALLERGIES	CURRENT MEDICATIONS
DRUG :	PRESCRIPTION :
FOOD :	OVER THE COUNTER :
OTHER :	

PRENATAL AND DELIVERY HISTORY		FAMILY HISTORY	
MOTHER'S AGE AT PREGNANCY:	☐ AIDS	☐ BIRTH DEFECTS	☐ MUSCULAR DYSTROPHY
ILLNESS DURING PREGNANCY:	☐ DIABETES	☐ HEART DISEASE	☐ MENTAL ILLNESS
MEDS DURING PREGNANCY :	☐ CANCER	☐ HIGH BLOOD PRESSURE	☐ SUDDEN INFANT DEATH
BIRTH WEIGHT: APGAR:	☐ CONVULSIONS	☐HIGH LIPIDS (CHOL/TRIG)	☐ THYROID DISEASE
TYPE OF DELIVERY :	☐ ALLERGIES	☐ KIDNEY DISEASE	☐ TUBERCULOSIS
WHERE DELIVERED :	☐ ASTHMA	☐ ANEMIA / BLOOD DISORDER	☐ ALCOHOL/DRUG ABUSE
COMPLICATIONS :	☐ MIGRAINE	☐ PSYCHIATRIC	☐ NONE

GROWTH AND DEVELOPMENT

PHYSICAL	AGE	SOCIAL	AGE	COMMUNICATION	AGE
Holds head up		Smiles		Coos	
Rolls over		Reaches for Objects		Laughs	
Sits alone		Drinks from cup		Laughs	
Walks		Scribbles		Babbles	
Jumps in place		Feeds self		First words	
Catches a ball		Toilet trained		Uses sentences	
Jumps rope		Draws triangle		Reads words	
Rides a bicycle		Dresses self		Tells story	

SOCIAL BEHAVIORAL
PRIMARY LANGUAGE :
Translation / Hearing Impaired Needs :
Grade in School : Performance in School:
Circle activity: day care preschool after school program Sport
AGES 8 YEARS & UP :
Do you smoke ? ☐ Yes ☐ No If yes, # of yrs
Drink alcohol ? ☐ Yes ☐ No Amount/day ____ /week
Take street drugs or smoke marijuana ☐ Yes ☐ No
Sexually active? ☐Yes ☐ No Using contraceptives? ☐ Yes ☐No

PAST HISTORY	
☐ Recurrent Ear Infections	☐ Lead Poisoning
☐ Frequent colds/Sore Throats	☐ Sickle Cell Anemia/Blood Disorder
☐ Asthma / Bronchitis	☐ Seizures
☐ Tonsillitis	☐ Stomach problems
☐ Allergies	☐ Heart Murmur
☐ Urinary Tract Infections	☐ Diabetes
☐ Chicken Pox	☐ Bed Wetting
☐ Injuries :	☐ Surgeries:
☐ Blood Transfusion(s)	☐ Hospitalized:
LAST TB SCREENING ☐ Pos (+) ☐ Neg(-) Age Performed :	Immunization's up-to-date: ☐Yes ☐No
Immunization Record Available ☐ Yes ☐ No (If no, bring record)	

Do you or any member of your family or close contact have tuberculosis? ☐ YES ☐ NO

Contact with persons in jail/prison in past 5 years.

Have you or any member of your family or close contact traveled outside the country ?

Frequently (Every 2-3 years) exposed to the following:

- ☐ HIV + persons
- ☐ Homeless persons
- ☐ Residents of nursing homes
- ☐ Institutionalized persons
- ☐ IV / street drug users

Completed by: _____

Nurse / Doctor Signature: _____ Date: _____

PALMETTO PEDIATRICS

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEGEMENT FORM.

I, _____ (Patient's Name), have reviewed/received a copy of PALMETTO PEDIATRIC'S Notice of Privacy Practice.

_____

Parent Signature

_____

Date:

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

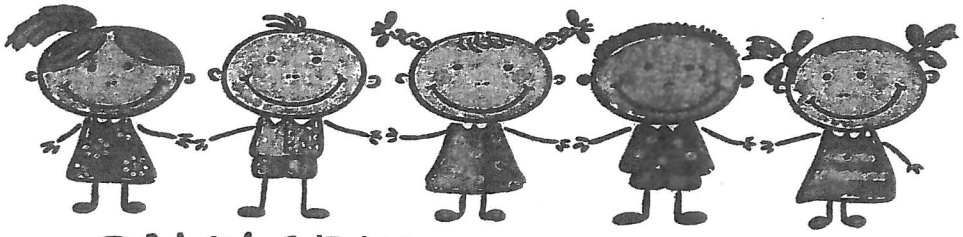
Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at _____, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis will not involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with _____ to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature of Patient	
Printed Name of Patient	
Personal Representative	
Date	



PALMETTO PEDIATRICS

218 9TH Street Drive West,
Palmetto, FL 34221
PH: 941-721-3900
FX: 941-721-7403

Authorization for Release of Medical Information
(Autorizacion para proporcionar Informacion Medica)

Date/Fecha: _____

I hereby give my permission to transfer all medical records form:
Yo por este medio doy mi permiso de transferir todos los historiales medicos:

_____

(Name of Previous Doctor) (Nombre Del Medico Anterior)

_____

(Phone number/Fax number) (Numero de telefono/Numero de fax)

I hereby release the facility from any liability which may arise because of the use of the information contain in the records released.
Yo por este medio relevo a esta empresa de cualquier responsabilidad que puede surgir como resultado de uso de la informacion contenida en los documentos remitidos.

If available parent/Guardian agrees to release the following records also:
-Alcohol & drug abuse cases
-Psychiatric/Psychogical Treatments
-HIV/AIDs Tests results & Diagnosis

Name of Patient: _____ Date of Birth: _____
(Nombre del Paciente) (Fecha de Nacimiento)

Signature of Parent/Guardian: _____
(Firma del Padre/Madre o Responsable)

Print Parent's/Guardian's Name: _____
(Nombre del Padre/Madre o Responsable)

Signature of Witness: _____
(Firma del Testigo)

To receiving Agency: **we prefer that you fax the medical records or mail a CD.**
Prohibition of Redisclosure This information has been disclosed to you from records whose confidentiality is protected. Any Further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information. Consent is Subject to revocation at any time.
MEDICAL RELEASE FORM2018 palmetto peds
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