Attention: **New Patients**

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

1. Parent photo ID (i.e. driver's license, identification card, etc.)
2. Child's Social Security card (if already received)
3. Child's insurance card
4. Child's vaccine record
5. Previous medical records

Once again, thank you for choosing Palmetto Pediatrics as your child's medical home.

PATIENT INFORMATION (PLEASE PRINT)

TODAY'S DATE _____

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

ADDRESS: _____
Street City State Zip

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

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. # _____ Driver LIC # _____

INSURANCE INFORMATION

Primary Ins. Name _____
Ins. Address _____
_____

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

Secondary Ins. Name _____
Ins. Address _____
_____

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

In case of Emergency, who should be notified? _____ Phone _____
Pharmacy of choice: _____ Phone _____

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	**Date of Birth**	**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

218 9th St. Dr. West
Palmetto, Fl. 34221
941-721-3900ph
941-721-7403fax

Authorization for Release of Medical Information
(Authorizacion Proporcionar Informacion)

Date: _____

I hereby give my permission to transfer all medical records from:
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 as a result of the use of the information contained in the records released.
Yo por este medio relevo a esta empresa de cualquier reponsabilidad que pueda surgir como resultado de uso de la informacion contenida en los documentos remitidos.

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

Signature of Parent/Guardian: _____
(Firma del padre/madre-custodio)

Print Parent's/Guardian's name: _____
(Escriba el nombre del padre/madre-custodio)

Signature of Witness: _____

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.

EXHIBIT 4

PALMETTO PEDIATRICS
Practice Name

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of PALMETTO PEDIATRICS's Notice of
Patient Name

Privacy Practices.

_____
Signature of Patient

_____
Date