

# Future Pediatrics

12216 Panama City Beach Pkwy – Suite B  
Panama City Beach, FL 32407  
Ph: (850) 236-0488  
Fx: (850) 249-0917



Today's Date: \_\_\_\_\_

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Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Child SSN: \_\_\_\_\_ M { } F { }

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Mobile Phone: ( ) \_\_\_\_\_ SMS/Text OK? Y { } N { } Email: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer/Ph #: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer/Ph #: \_\_\_\_\_

Legal Guardian's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer/Ph #: \_\_\_\_\_  
(IF OTHER THAN PARENT)

## Emergency Contact *OTHER THAN PARENT*

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Ph#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## Closest Relative *Address other than patient*

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Ph#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## **Insurance and Billing Information**

Person Responsible: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Policy Effective Date: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Number: ( ) \_\_\_\_\_

Billing Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

### ***Payment required at the time of service, unless prior arrangements have been made.***

1) Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

2) Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### ***Assignment of Insurance Benefits***

I hereby authorize direct payment of surgical/ medical benefits to Future Pediatrics for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

### ***Authorization to Release Information***

I hereby authorize Future Pediatrics to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

### ***Medicaid***

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Parent/Guardian (*please print*): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Reason for Today's Visit: \_\_\_\_\_

Please check {Y} yes or {N} no, explain where required.

**Pregnancy & Birth**

Mother's age at pregnancy: \_\_\_\_\_ Any illness during pregnancy? {Y} {N} Medication during pregnancy? {Y} {N}

Smoking, alcohol, street drugs during pregnancy? {Y} {N} Was baby early, late, on-time: \_\_\_\_\_ Any Complications? \_\_\_\_\_

Type of delivery: {Vaginal} {C-section} Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Problems soon after birth? At nursery or home? \_\_\_\_\_

**Past Medical History of Patient**

Allergic reactions {Y} {N} Food {Y} {N} Animals {Y} {N} Insect bites {Y} {N} Explain: \_\_\_\_\_

Medications taken regularly? {Y} {N} List medications: \_\_\_\_\_ Immunizations up to date? {Y} {N} Do you have a record? {Y} {N}

Hospitalizations? {Y} {N} If yes, When-Where-Why: \_\_\_\_\_

Serious Injuries? {Y} {N} If yes, When-Where-Why: \_\_\_\_\_

Red Measles	{Y} {N}	Mumps	{Y} {N}	German Measles (3 day)	{Y} {N}	Anemia	{Y} {N}
Chicken Pox	{Y} {N}	Whooping Cough	{Y} {N}	Hepatitis	{Y} {N}	Bleeding Tendency	{Y} {N}
Scarlet Fever	{Y} {N}	Ear Infections	{Y} {N}	Urinary Infections	{Y} {N}	Blood Transfusions	{Y} {N}
Asthma/Wheezing	{Y} {N}	Eczema/Hives	{Y} {N}	Joint Problems	{Y} {N}	Rheumatic Fever	{Y} {N}
Strep Throat	{Y} {N}	Seizures	{Y} {N}	Hearing Problems	{Y} {N}	Vision Problems	{Y} {N}

**Feeding & Nutrition**

Food Allergies {Y} {N} List (if any): \_\_\_\_\_ Normal Appetite? {Y} {N} Colic/Feeding problems during first 3 months? {Y} {N}

Breast Fed? {Y} {N} Number of months? \_\_\_\_\_ Formula? {Y} {N} Current Brand: \_\_\_\_\_

Vitamins/Supplements? {Y} {N} What brand? \_\_\_\_\_ Special Diet? {Y} {N} Fluoride? {Y} {N}

**Family Profile**

Parents are: Married { } Separated { } Divorced { } Unknown { }

Father's Age: \_\_\_\_\_ Highest grade school completed: \_\_\_\_\_ Health: \_\_\_\_\_

Mother's Age: \_\_\_\_\_ Highest grade school completed: \_\_\_\_\_ Health: \_\_\_\_\_

List the child's siblings and their ages: \_\_\_\_\_

**Family Medical History**

List all blood relatives of the child who have the following conditions. Use abbreviations - {F} Father, {M} Mother, {B} Brother, {S} Sister, {MM} Mother's mother, {MF} Mother's father, {FM} Father's mother, {FF} Father's father, {A} Aunt, {U} Uncle, {C} cousin

Anemia/Blood Disorder: _____	Asthma: _____	Mental Retardation: _____
Drug Problem: _____	Alcoholism: _____	Cancer: _____
Aids: _____	Cystic Fibrosis: _____	Muscular Dystrophy: _____
Tuberculosis: _____	Arthritis: _____	Epilepsy/Seizures: _____
Heart Disease: _____	High Blood Pressure: _____	Cholesterol Issues: _____
Migraines: _____	Sudden Infant Death: _____	Birth Defect: _____
Early deafness: _____	Diabetes: _____	

**Development & Behavior:**

At what age did the child: Sit alone \_\_\_\_\_ Walk \_\_\_\_\_ Use sentences \_\_\_\_\_ Toilet trained \_\_\_\_\_ Bicycled \_\_\_\_\_

Grade in school: \_\_\_\_\_ Problems in school? {Y} {N} Learning problems? {Y} {N} Getting along with other children? {Y} {N}

Behavior concerns? {Y} {N} Bad habits? {Y} {N} Bedwetting? {Y} {N} Nail biting? {Y} {N} Use of illegal or steet drugs? {Y} {N}

Hobbies? {Y} {N} Sports? {Y} {N}

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please select and complete **ONE** of the following options (only A or only B).

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

### **Option A - Authorization of Other Persons for Patient Transport**

**A)** \_\_\_\_\_ I, \_\_\_\_\_ authorize the following person/persons to  
(Please Initial) (Name of Parent/Legal Guardian)

bring my child to his/her appointment in case of my absence:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

***/OR/***

### **Option B - Authorization of Parent/Guardian ONLY for Patient Transport**

**B)** \_\_\_\_\_ I, \_\_\_\_\_ authorize NO ONE to bring my child to  
(Please Initial) (Name of Parent/Legal Guardian)

his/her appointment, only MYSELF.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**PEDIATRIC OFFICE POLICIES**

Please review our office policies carefully and sign at the bottom. If you have any questions, please refer them to our staff.

**1. Walk-In Appointments:** Your child will be worked into the schedule as soon as possible. Keep in mind that priority may be given to patients with a pre-scheduled appointment. Walk-in appointments are accepted for sick patients only. If your child needs a Well-Child Check-up/Physical, we can schedule that for the next office day. If your child needs a medication refill, see below number 7- *Medication Refills*.

**2. Missed/Late Appointments:** If you find that you will not be able to make your child's scheduled appointment, we ask that you call at least 24 hours in advance to let us know. If you have (3) No-Call/No-Show appointments, we reserve the right to dismiss you as a patient of our practice. If you are more than 15 minutes late for your scheduled appointment time, and we were not notified by a courtesy call, you may be asked to reschedule your child's appointment.

**3. NO SMOKING.** Please review the accompanying No Smoking Policy for further information regarding this policy.

**4. Any damage to Future Pediatrics property or property of its employees** may result in immediate dismissal as a patient from our practice. Additionally, **Food and Drinks are not permitted in the waiting area and exam rooms.**

**5. Co-pays & Office Visit Fees:** All insurance co-payments and office visit fees are to be paid BEFORE you are seen by the doctor. If your insurance is not active when you check-in, you will be asked to pay the full office visit fee or to reschedule to another date when the insurance will be active.

**7. Medication Refills:** Please allow 72 business hours for ALL medication refill requests to be transmitted to the pharmacy of your choice. To ensure that your child does not deplete a supply of his/her medication, please call us at least one week prior to the last medication dose/refill date.

**ADHD medications** can NOT be called-in or transmitted to a pharmacy; your child is required to be seen in an office visit with the doctor each month, prior to an ADHD-related prescription being provided.

**8. Shot Records & Administrative Documentation:** Our office policy requires 72 business hours' notice for any shot record/immunization history requests, as well as any administrative documentation requiring a provider's signature. Please keep this in mind when requesting shots/immunizations records.

**9. Medical Records:** Medical records will be released ONLY to another provider, after receiving a medical records release form signed by the child's parent or legal guardian. If transferring medical care to another primary provider, we will provide copies of your child's immunization record and treatment plan directly to the new provider, at no cost. If paper hard-copies of any medical records (other than immunization history) are needed, please discuss this with a Future Pediatrics staff member.

**10. Identification:** You, or your authorized representative, must provide a valid photo ID when bringing your child to our office.

**11. Changing Tables:** For your convenience, we supply our patients with a changing table in the patient-accessible bathroom. Please use the bathroom trash to dispose of soiled diapers. Please do NOT use the trash cans in the exam rooms.

**12. Authorizing Someone to Bring Your Child:** ABSOLUTELY NO ONE CAN BRING YOUR CHILD TO OUR OFFICE, UNLESS THERE IS WRITTEN CONSENT ON FILE OR PROVIDED AT THE TIME OF THE APPOINTMENT. **If you authorize another person to accompany your child during any office visit, that person must be a legal guardian/authorized adult that is 18 years of age or older.**

By signing below, I certify that I have read and understand the office policies.

Parent / Guardian Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Assignment of Insurance Benefits**

I, hereby, authorize direct payment of medical benefits to Future Pediatrics for services rendered by him/her in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Authorization to Release Information**

I, hereby, authorize Future Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing applications for financial benefits.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**HIPAA Privacy Policy**

The HIPAA Privacy Policy and the Notice of Privacy Practices attached to this letter explains our policies in these matters. It contains very important information on how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Private Officer at (850) 747-8787, or discuss any questions you may have with your physician.

By signing below, I certify that I have read and understand the HIPPA privacy policy.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Notice of Privacy Act**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This is to certify that I, \_\_\_\_\_ have received a copy of the Notice of  
(Name of Parent/Legal Guardian)

Privacy Act, and I understand it.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# **NO SMOKING POLICY**

**Our Pediatric office is a non-smoking facility.**

**We do not allow any smoking in the vicinity of the office or in the parking area, for the health of our staff and pediatric patients.**

**Because we care for the health of our patients, we also ask that you do not smoke before coming to your appointments. Smoke particles stay on your clothes for quite some time, even if you smoke outside, and it may flare-up asthma and allergy symptoms in a patient exposed to smoke particles, resulting in a deterioration of his disease.**

**Any smoke odor from a parent may result in discharge of that family from the practice, without any further warning.**

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Signature of Parent/Legal Guardian

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Date

# Future Pediatrics

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## Request for Release of Medical Records

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_  
Patient's Previous Doctor / Pediatrician / Clinic

\_\_\_\_\_  
Previous Clinic's Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

( ) \_\_\_\_\_  
Previous Clinic's Phone Number

( ) \_\_\_\_\_  
Fax Number

By signing below, I authorize the above listed facility to release this patient's **medical records** and **immunization history** to Future Pediatrics, at the address or fax provided in the above letterhead. This is being requested in order for Future Pediatrics to continue providing healthcare services to this patient.

This authorization expires 5 years after the date signed, and re-disclosure of this information may be sent to another entity if I so authorize. I may choose to revoke this authorization by providing a written request to all parties.

\_\_\_\_\_  
*Signature of Patient's Parent/Legal Guardian*

\_\_\_\_\_  
*Date*