Future Pediatrics

Select Office Location:

292 Forest Park Circle
Panama City, FL 32405
Ph: (850) 767-4777
Fx: (850) 763-4988

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

Today's Date: _____ <Page 1>

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 serviced 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: _____
Drug Problem: _____
Aids: _____
Tuberculosis: _____
Heart Disease: _____
Migraines: _____
Early deafness: _____

Asthma: _____
Alcoholism: _____
Cystic Fibrosis: _____
Arthritis: _____
High Blood Pressure: _____
Sudden Infant Death: _____
Diabetes: _____

Mental Retardation: _____
Cancer: _____
Muscular Dystrophy: _____
Epilepsy/Seizures: _____
Cholesterol Issues: _____
Birth Defect: _____

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 <u>ONE</u> of the following options (only A or only B).

Patient Name: _____ Patient Date of Birth: _____

<u>Option A</u> - 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.

_____ _____

Signature of Parent/Legal Guardian **Date**

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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 indicated 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*