FUTURE PEDIATRICS

DR. AHMED BAKER-MOHAMED
DR. AHMED REZK
292 FOREST PARK CIRCLE
PANAMA CITY, FL 32405
PH: (850) 767-4777
FX: (850) 763-4988

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 Dr. Ahmed Baker-Mohamed, M.D., for serviced rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Dr. Ahmed Baker-Mohamed, M.D., 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 **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

Patient Name: _____ Date of Birth: _____

PEDIATRIC OFFICE POLICIES

Please review our office policies carefully and then sign that you understand them. 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 20 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.

4. Please NO food or drinks in the waiting area or 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 run-out of his/her medication, please call us at least one week prior to the last medication dose.
ADHD medications can NOT be called-in; your child is required to be seen in an office visit with the doctor each month, prior to a prescription being given.

8. Shot Records: Our office policy requires 72 business hours notice for any shot records requests. Please keep this in mind when requesting shots/immunizations records.

9. Medical Records: We will release medical records ONLY to another doctor from whom we have received a faxed or mailed medical records release form signed by the child's parent or legal guardian. If you are moving out of the area, and you need your child's medical records, we will be happy to provide copies of your child's immunization record and your child's treatment plan.

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.

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 Dr. Baker-Mohamed 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.

Authorization to Release Information

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

Parent/Legal Guardian:

Please sign and date this form, along with your registration forms. By doing this, you are acknowledging that you have received a copy of our Notice of Privacy Practices and HIPAA guidelines.
Thank you for your consideration in this matter.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Relationship to Child

Patient Name: _____ Date of Birth: _____

HIPAA Privacy Policy

Dear Patient:

Physicians have always protected the confidentiality of health information by sealing medical records away in filing cabinets and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the private of your health information. This "privacy rule" also known as HIPAA (Health Portability and Accountability Act) protects health information that is maintained by physicians, hospitals and other health care providers and health care plans.

This new regulation protects virtually all patients regardless of where they live or where they received their healthcare. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to the health plan, your healthcare provider will need to consider the privacy rule. All health information, including paper records, oral communication and electronic formats (such as email, are protected by the privacy rule).

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also, take precautions in our office to safeguard your health information, such as training our employees and employing computer security measures. Please feel free to ask the physician or our privacy officer about exercising your rights or how your health information is protected in our office.

The Notice of Privacy Practices attached to this letter explains our policy. It contains very important information on how your confidential health information is handles 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: _____

Parent/Guardian Name (please print): _____

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.

_____ _____
Signature of Parent/Legal Guardian 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 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*