THE KID'S DOCTOR

10549 N. Florida Avenue
Tampa, Florida 33612

PATIENT INFORMATION

Last Name: _____ First: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip code: _____

Birth Date: _____ Social Security #: _____ Male ❑ Female ❑

RESPONSIBLE PARTY

(GUARDIAN OR MOTHER)

Mother's Name: _____

Address: _____

_____

City State Zip Code

Birth Date: _____

Driver's License #: _____

Social Security #: _____

Employer: _____

Address: _____

_____

City State Zip Code Phone #

Father's Name: _____

Address: _____

_____

City State Zip Code

Birth Date: _____

Driver's License #: _____

Social Security #: _____

Employer: _____

Address: _____

_____

City State Zip Code Phone #

IN CASE OF EMERGENCY

NAME OF NEAREST RELATIVE (Not at same address)

Name: _____ Relationship: _____

Address: _____ Phone #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

I.D. Number: _____ Plan Type: _____

Subscriber Name: _____ Insurance Phone #: _____

Other: _____

I understand I am directly responsible for all charges regardless of insurance coverage. I furthermore agree to pay legal, collection expenses and attorney's fees should it become necessary to assign any amount I may owe for collections.

I also assign the insurance payments to The Kid's Doctor. I understand the office will refund to me promptly any overpayments of my account.

I understand that medical evaluation and/or treatment is necessary for the patient and that medical evaluation, treatment and procedures will be performed by the health care provider and/or employee of The Kid's Doctor.

I hereby grand my authorization to such care and treatment and certify that no guarantee or assurance has been made as to the result which may be obtained.

I understand that it is my responsibility to return to the office and/or report any change in my condition to the health care provider.

The undersigned certifies that he/she has read the above, and is the patient, guarantor, or the patient's representative duly authorized to execute this agreement and accept its terms.

Date: _____ **X** _____

Witness: _____ Relationship to Patient: _____

INSURANCE AUTHORIZATION

HEALTH CARE INSURANCE PLAN OBLIGATION: THE KID'S DOCTOR maintains a list of the health care service plans with which it has contracted to provide services to patients. THE KID'S DOCTOR has agreed to bill those insurance carriers for all services rendered. Authorization from your insurance company does not always guarantee payment. The undersigned and/or patient shall remain responsible for all charges, applicable to co-payments and deductibles. Payment to the THE KID'S DOCTOR is due upon receipt of statement.

Initials of Patient or Responsible Party:_____

PPO/HMO/MEDICAID/TRADITIONAL INSURANCE WAIVER REGARDING NON-COVERED SERVICES: Medicaid and some health insurance plans will only pay for services that it determines to be "reasonable and necessary." If Medicaid or your health insurance plan determines that a particular service is not "reasonable and/or necessary" under the program standards; or your insurance determines that a service(s) was unauthorized or not a covered benefit under your plan, Medicaid and other insurance plans will deny payment for these services. We believe that, according to your insurance/Medicaid plan, payment is like to be denied for the following service(s):

- Routine Physicals (no symptoms/complaints)
- Durable Medical Equipment (crutches, splints, bandages, etc.)
- Lab Tests for Screening Purposes (including Chest X-Rays/EKG)
- Routine Immunizations
- Prescription Drugs
- Other:_____

Initials of Patient or Responsible Party:_____

RELEASE OF MEDICAL INFORMATION / ASSIGNMENT OF BENEFITS:

A. I hereby authorize THE KID'S DOCTOR to release any medical information in connection with these services for health insurance purposes or to the patient's personal physician.

B. I hereby authorize THE KID'S DOCTOR to release any medical information to Medicaid and or its intermediaries. A copy of this form can be used in place of the original.

C. I hereby authorize and direct payment to THE KID'S DOCTOR for the medical and/or surgical benefits, if any, otherwise payable to me under the terms of my insurance.

Initials of Patient or Responsible Party:_____

The undersigned certifies that he/she has read the above, and is the patient, guarantor, or patient's representative duly authorized to execute this agreement and accept its terms.

_____ _____

Date Signature of Patient or Representative

_____ _____

Witness Representative's Relationship to Patient

THE KID'S DOCTOR
10549 N. Florida Avenue
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(813) 978-1522 • Fax (813) 971-3330

Child's Name *(Nombre)*: _____

Child's Birthdate *(Fecha de Naciamiento)*: _____

Today's Date *(Fecha de Hoy)*: _____

HISTORY SHEET *(Historica Clinica)* #1

Is your child allergic to anything *(Es su hijo alérgico a algo)*? ❑ Yes ❑ No If Yes, what *(Si lo es, a qué)*?: _____

Is your child taking any medication *(Está su hijo tomando alguna medicina)*? ❑ Yes ❑ No If Yes, what *(Si lo es, a qué)*?: _____

Is your child up to date with his immunizations *(Está su hijo al dia en las vacunas)*? ❑ Yes ❑ No

Do your have your child's shot record with you *(Tiene su record de vacunas)*? ❑ Yes ❑ No

Has your child ever been in the hospital *(Ha estado su hijo alguna vez hospitalizado)*? ❑ Yes ❑ No
If yes, when and for what reason *(Si lo ha estado, cuando y por qué)*? _____

Does your child have any health problems *(Tiéne su hijo alguna enfermedad)*? ❑ Yes ❑ No
If yes, what *(Si la tiene que és)*? _____

Has your child ever had *(Ha tenido su hijo)*?:

Chickenpox *(Chinas)*:	❑ Yes	❑ No	If yes, when *(Si lo cuando)* _____
Measles *(Sarampión)*:	❑ Yes	❑ No	If yes, when *(Si lo cuando)* _____
Mumps *(Paperas)*:	❑ Yes	❑ No	If yes, when *(Si lo cuando)* _____
Ear Infections *(Infecciones de oido)*:	❑ Yes	❑ No	If yes, when *(Si lo cuando)* _____

BIRTH HISTORY *(Historical De Nacimiento)*

Was the baby: ❑ **Full Term** ❑ **Early** ❑ **Late** *(Fue su bebe a término?* ❑ ***Término*** ❑ ***Prematuro*** ❑ ***Postmaduro)***

Birth Weight *(Peso al Nacer)*: _____ Length *(Longitud)*: _____

Was the baby born: ❑ **Vaginally** or by ❑ **C-Section** *(Nació el bebe via:* ❑ ***Vaginal*** *o por* ❑ ***Cesarea)***

Mother's age at Birth *(Edad de la madre al nacer)*: _____ Was this a first pregnancy *(Primer embarazo)*: ❑ Yes ❑ No

Were there any problems during the pregnancy *(Hubo algun problema durante el embarazo)*? ❑ Yes ❑ No
If yes, what *(Si lo hubo cuál)*? _____

Did the baby have any problems when first born (Tuvo el bebe algun problema cuando nació): ❑ Yes ❑ No
If yes, what *(Si lo hubo cuál)*? _____

FAMILY MEDICAL HISTORY *(Historical Medico Familiar)*

Does anyone in the family have the following *(Hay alguien en su familia que padacede)*:

❑ Diabetes ❑ Cancer ❑ Heart Disease *(Enfermedad de carazión)*
❑ Heart Attack (Ataque al corazon) ❑ High Blood Pressure *(Presion alta)*
❑ Stroke (Ataque cerebral) ❑ Allergies (Alergiás) ❑ Asthma *(Asma)* ❑ Sickle Cell
❑ Seizures (Convulsiones) ❑ Mental Retardation *(Retraso Mental)*
❑ Emotional or Mental Illness *(Enfermedad mental o emocional)*
❑ Has anyone in your family had tuberculosis or been exposed to it *(Ha tenido alquién en su familia, o ha estado expuesto alquián a la tuberculosis)?* ❑ Yes ❑ No
❑ Does anyone in your family smoke *(Hay alquián que fuma en su familia)*? ❑ Yes ❑ No
❑ Other *(Otras)*? _____

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HISTORY SHEET *(Historica Clinica)* #2

NUTRITION *(Nutricion)*

BABY - For Children Under 1 Year *(PARA NINÓS MENOS DE UN AÑO)*

Is your baby on formula *(Su bebe toma formula)*? ❑ Yes ❑ No If yes, which *(Si lo cuál)*? _____

How much formula does the baby drink at one feeding (Cuanta formula toma su bebe cada vez)? _____

How often *(Con que frequencia)*?_____ Baby food *(Comida de bebe)*: _____

Juice *(Jogo)*:_____ Cereal:_____ Table food *(Comidas de Adulto)*: _____

What type of water does your baby drink *(De que agua le da a su bebe)*? ❑ Tap *(agua de ciudad)* ❑ Bottled *(embotellada)*

OLDER CHILDREN - For Children 1 Year and Older *(NINÓS MAYORES DE MAS DE UN AÑO)*

Does your child have a good appetite *(Tiene su hijo buen apetito)*? ❑ Yes ❑ No

Does your child eat food of all the major food groups (Come de todos: Los grupos principales de comida)?

What type of water does your child drink *(De que agua le da a su bebe)*? ❑ Tap *(agua de ciudad)* ❑ Bottled *(embotellada)*

DEVELOPMENT *(Desarrollo)*

Age Expected	Physical Gross Motor	Age Achiev	Social Fine Motor	Age Achiev	Communication	Age Achiev
0-3 mos *(0-3 meses)*	holds head up *(mantiene su cabeza derecha)*		smiles *(sonrie)*		coos *(amite sonido)*	
4-6 mos *(4-6 meses)*	rolls over *(se da la vuelta)*		reaches for objects *(trata de coger objetos)*		laughs *(se rie)*	
7-10 mos *(7-10 meses)*	sits alone *(se sienta solo)*		drinks from cup *(bebe de un vaso)*		babbles *(gorgojea)*	
11-15 mos *(11-15 meses)*	walks *(camina)*		scribbles *(hace garabatos)*		first words *(primeras palabras)*	
16-24 mos *(16-24 meses)*	jumps in place *(salta)*		feeds self with spoon *(use cucherita para comar)*		combines 2 words *(combina dos palabras)*	
2-3 yrs. *(2-3 anos)*	broad jumps *(salte adelante)*		toilet trained *(avisa o va al bano solo)*		uses sentences *(usa oraciones al hablar)*	
4-5 yrs. *(4-5 anos)*	catches ball *(si le tiras una pelota la coge en el aire)*		dresses self *(se viste)*		tells stories *(cuenta cuentos)*	
6-8 yrs. *(6-8 anos)*	jumps rope *(salta a la cuerda)*		draws triangle *(dibuja un triangulo)*		reads words *(les palabras)*	
9-10 yrs. *(9-10 anos)*	rides bicycle *(monte bicicleta)*		does household chores *(hace tareas de la casa)*		tells time *(dice le hora)*	

What grade is your child in *(En que grado está su hijo)*? _____

How is your child doing in school *(Como le vá en la escuela)*? _____

Does your child get along with his classmates *(Se relaciona bien con sus compañeros)*? _____

Any problems *(Hay algún problema)*? _____

Signature of Parent or Guardian *(Firma de uno de los padres)* _____

THE KID'S DOCTOR

****Due to the new Red Flag Rules set by the FTC, you are required to fill out the following information and provide your picture ID & insurance card to the front desk. All information MUST be filled out entirely, without this information we will have to reschedule your appointment.**

Date: ___/___/ 20___

Patient Name: _____ DOB: ____/___/____

Patient Social Security #: _____-_____-_____ ○ Female ○ Male

Insurance Co. Name: _____ ID#: _____

Parent Name: _____ Relationship:_____

Parent DOB: ____/_____/____ Parent SS#: ____- ___- ____ Phone: ___-____-___

Residence: _____-_____

City _____ State _____ Zip code _____

****Please list other parents name and DOB along with anyone that's allowed to bring your child to their appointment and/or to make changes to your child's information.**

☐ **Parent refused to provide information

Parent Initials

Parent name: _____DOB: ___/___/___ Relationship: _____

Name: _____ Ph. #:___-___-____ Relationship: _____

Name: _____ Ph. # ____-____-_____ Relationship: _____

****Please list any other children that are patients in our office.**

Child's Name: _____ DOB: _____/____/_____

Child's Name: _____ DOB: _____/____/_____

Child's Name: _____ DOB: ____/_____/_____

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THE KID'S DOCTOR

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, THE KID'S DOCTOR may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to THE KID'S DOCTOR's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

THE KID'S DOCTOR reserves the right to revise its Notice of Privacy Practice at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to THE KID'S DOCTOR Privacy Officer at 10549 North Florida Avenue, Suite B, Tampa, Florida 33612.

With my consent, THE KID'S DOCTOR may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, THE KID'S DOCTOR may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, THE KID'S DOCTOR may email to me appointment cards and patient statements.

I have the right to request THE KID'S DOCTOR restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to THE KID'S DOCTOR's use and disclosure PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, THE KID'S DOCTOR may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

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THE KID'S DOCTOR

CONSENT FOR RELEASE OF MEDICAL INFORMATION AND/OR X-RAY FILMS

Patient Name: _____ SS #: _____

D.O.B: _____ Phone #: _____

I authorize _____

Name of Facility / Person maintaining medical information

to release copies of my medical records to: _____

_____

Name of Facility or Person and Address

A. I authorize release of information for:
- _____ medical care (physicians, etc..)
- _____ personal use
- _____ other: _____
  employer, Insurance, attorney, etc.

B. I am transferring from medical office _____

to _____

C. I authorize release of my (refer to section d, if applicable)
- _____ entire medical record

-or-
- _____ medical records for the specific treatment dates from _____
- _____ to_____.

D. I authorize release of the following portions of my medical record:
(write your initials beside each area to be included in release).
- _____ Diagnosis &/or treatment for mental health/rehabilitation (FL Statute 455.241)
- _____ Diagnosis &/or treatment for alcohol &/or substance abuse (FL Statute 396.112) and C.F.R. 42 part 2)
- _____ HIV antibody test and/or AIDS diagnosis &/or treatment (FL Statute 381.004)
- _____ Genetic Testing

E. I authorize release of x-ray films, #_____.

to _____

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing). I also understand that this authorization will remain in effect for ninety (90) days unless I specify an earlier date here:_____

I have carefully read tne information above and the attachment that explains that my medical record may contain information that is considered "super confidential". I have had the opportunity to ask questions and I request that my medical records be released as designated.

Date: _____ _____

Witness

_____ _____

Signature of Patient or Representative Relationship to Patient (If Applicable)

Physician's Signature:

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LEAD RISK ASSESSMENT QUESTIONS

❑ Yes ❑ No 1. Since the last oral risk assessment, have there been any significant changes in day care, your home, hobbies, or occupation? (If no, using the medical provider's professional judgment, only pertinent questions to assess current risk should be asked, such as #7).

❑ Yes ❑ No 2. Has the mother of the infant worked or lived where she has been exposed to lead?

❑ Yes ❑ No 3. Does your child live in or frequently (once a week or more) visit a house built before 1960? Was your child's day care center / preschool / baby sitter's home built before 1960? Does the houose have peeling or chipping paint inside or outside? Is there old furniture or painted woodwork that your child can chew on (crib, bannister)? Does your child exhibit pica?

❑ Yes ❑ No 4. Does your child live in a house built before 1980 with recent, ongoing or planned renovation or remodeling?

❑ Yes ❑ No 5. Does your child live in or frequently visit a home near a heavily traveled major highway where soil and dust may be contaminated with lead? Is your child's day care near a busy road?

❑ Yes ❑ No 6. Does your child regularly eat from ceramic or pewter dishes? Is food stored in tin cans, ceramicware, or pottery?

❑ Yes ❑ No 7. Have any of your children or their playmates had lead poisoning?

❑ Yes ❑ No 8. What are the occupations of all household members and frequent visitors? Does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery, or other trades practiced in your community. Does anyone in the household have a hobby which uses lead? Examples are fishing weights, casting ammunition, toy soldiers, making stained glass, making pottery, refinishing furniture, burning lead-painted wood. Ask those appropriate for your area.

❑ Yes ❑ No 9. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? Does your child love near a source of current industrial pollution or on the site of the old industry or mining?

❑ Yes ❑ No 10. Do you give your child any home or folk remedies which may contain lead? The medical provider should note that many of these remedies are no longer legal in the U.S., and there may be some reluctance to discuss them. Examples of remedies containing lead are: Alarcon, Alkohl, Azarcon, Bali Goli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, and Rueda.

❑ Yes ❑ No 11. Does your home's plumbing have lead pipes or copper with lead solder joints? Have there been any plumbing repairs or fixtures added within the last 5 years?