Pinecrest Pediatrics Group
11635 S. Dixie Highway
Pinecrest, FL 33156
Tel: 786-250-5224
Fax:786-227-6068

www.pinecrestpeds.com

PATIENT INFORMATION

Date: _____

(Please list all children in the family even if the child is not being seen today)

	Child 1	Child 2	Child 3	Child 4	Child 5
Last Name					
First Name					
Middle					
DOB					

PARENTAL INFORMATION

MOTHER/LEGAL GUARDIAN

Name_____
DOB _____ SSN# _____
Mailing Address _____
_____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer _____
Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed
Preferred Language_____
Step Father _____

FATHER/LEGAL GUARDIAN

Name_____
DOB _____ SSN# _____
Mailing Address _____
_____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer _____
Marital Status

Single ☐ Married ☐ Divorced ☐ Widowed
☐
Preferred Language_____
Step Mother _____

Pharmacy Name _____ Address _____Phone # _____
Who do the children reside with? ☐Both Father Mother Other ☐ _____ Who has legal custody of child/children? Both Father Mother Other ☐ ☐ _____ **Please provide any applicable legal documents.**

Who is responsible for the medical bills? ☐ Father ☐ Mother ☐ Other _____
Which phone # should we list as your primary contact? _____ Is it ok to leave a message at this #?_____
For patients over the age of 18: What is <u>your</u> preference in communication? _____Is it ok to email you? _____
☐ Phone _____ ☐ Email_____

INSURANCE INFORMATION

PLEASE NOTE: YOU WILL BE ASKED TO PRESENT YOUR INSURANCE CARD AT **EVERY VISIT**

PRIMARY INSURANCE

Insurance Company_____
Insurance Effective Date_____
Insured's Name_____
Insured's DOB_____
ID#_____ Group#_____
Employer_____

SECONDARY INSURANCE

Insurance Company_____
Insurance Effective Date_____
Insured's Name_____
Insured's DOB_____
ID#_____ Group#_____
Employer_____

EMERGENCY CONTACT (Other than Parent)

Name_____ Relationship _____
Home Phone_____ Cell Phone _____ Work Phone _____

Signature of Parent/Guardian: _____ **Date:** _____

How did you hear about our practice? ☐ Yellow Pages Online ☐ RTP Links ☐ Friend/Family/Neighbor ☐ Other Physician

☐ Online (name of website) _____ ☐ Other _____

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PATIENT'S NAME:_____ DATE OF BIRTH:_____

ACKNOWLEDGEMENT OF HIPAA RIGHTS

_____ I do hereby acknowledge that Pinecrest Pediatrics Group LLC has provided me with a notice of the privacy practice, as required by the Federal HIPAA Law. I understand that I will be provided a copy of the Policy, upon my request. I understand the Privacy Practices are posted on www.pinecrestpeds.com

_____ I authorize for Pinecrest Pediatrics LLC to leave medical information on voicemail at the phone numbers listed on my child's account.

RELEASE OF INFORMATION

_____ I authorize the release of any medical information necessary to process a claim

_____ I authorize payment of medical benefits to myself or the named provider of professional services rendered.

PARENTAL AUTHORIZATION TO TREAT MINOR CHILDREN

WHEN ACCOMPANIED OR NOT ACCOMPANIED BY PARENT OR GUARDIAN

_____ Yes, my child may be treated with Parent or Guardian
_____ Yes, my child may be treated when accompanied by:

Name	Relationship	Name	Relationship

_____ Yes _____ No My child over 16 years old may present and be treated unaccompanied by an adult.

Signature of Parent or Legal Guardian _____ Date:_____

Pinecrest Pediatrics Group

Notice of Policies

Payment Policy

Please be prepared to present your insurance card and Identification Card at every visit. Ensure that our pediatricians actively participate with your insurance carrier. Be aware of your insurance policy benefits and limitations. Make sure your insurance is current and active before your arrival. If we cannot verify coverage or there are services rendered that are not covered by your policy, it is your responsibility to pay in full at the time of the visit. All insurance co-payments and deductibles must be paid at the time of service. For your convenience, we accept Visa, MasterCard, Checks, and Cash.

Patients may receive and are responsible for bills for services sent to another facility such as a laboratory or diagnostic center which may not be covered by the insurance. Patients will be responsible for any bills of unpaid services including services that may have been denied or non-covered by your insurance carrier. Patients will be responsible for paying claims where either the practice or the insurance plan failed to receive accurate patient information. Statements will be mailed for unpaid services. Balances must be paid in 30 days. If a balance is due over 90 days and we have not been contacted to arrange payments, the account may be turned over to a collection agency. Please notify us if you are experiencing financial difficulty and we will work with you on developing a payment plan.

Additional Fees

There will be a $10.00 fee for each set of Florida Department of Health School Entry Health Exam and Certification of Immunization ("Blue and Yellow" Forms.) A copy of medical records released to a patient will have a $10.00 fee. Ear piercing performed by the physician will be charged $60.00 with a set of earrings included. Patients with non-urgent or routine labs may elect to have their venous blood drawn in the office for a charge of $25.00 in lieu of traveling to their local laboratory facility.

Late/Missed Appointment Policy

We appreciate a 24 hour notice on cancellations. We will try to accommodate any sick patient who arrives late with the next available open appointment. If you arrive more than 15 minutes late for a well checkup, you may be asked to reschedule.

Walk-In Policy

We see all patients by appointments and offer same day appointment scheduling. Unless deemed urgent, patients who arrive without an appointment will be given the next available open appointment. Saturday morning emergency appointments will be scheduled by the on-call physician.

Referral Policy

Many insurance companies require authorization through your pediatrician before seeing a specialist. This process can take up to 5 business days to complete. If your pediatrician believes your child should see a specialist, call the specialist, confirm the doctor is on your insurance plan, and make an appointment. Call our office back with the name of the specialist, the appointment date, and time. Allow 3-5 business days for the completion of your referral.

Prescription Refill Policy

Prescription refill requests should be emailed or phoned in during regular office hours. Provide all pertinent information including the patient's name, date of birth, medication name, dose, pharmacy name, pharmacy address and phone number. Allow up to 3 business days for us to prepare the prescription. Certain chronic and recurrent conditions may require a visit for re-evaluation before a refill is provided. We do not call in or refill antibiotics or oral steroids without having seen the patient first.

Thank you for understanding our policies. Please let us know if you have any questions.

I have received and read a copy of Pinecrest Pediatrics Group's Policies and agree to abide by them:

_____ / _____

Signature of Responsible Party Date

Patient History

Name_____ **Birth date**_____

	Date of Birth	Ht	Wt	Medical Problems	Education Level
MOTHER					
FATHER					

Family History

Is there a family history of any of the following (include child's parents, siblings, grandparents, aunts and uncles)?
Please check yes or no to all questions.

Diabetes	Yes ☐	No ☐	Allergies	Yes ☐	No ☐	Birth Defects	Yes ☐	No ☐
Asthma/Wheezing	Yes ☐	No ☐	Cancer	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Bleeding Disorder	Yes ☐	No ☐	High Cholesterol	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Thyroid disease	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Mental Problems	Yes ☐	No ☐	Early Heart Attacks	Yes ☐	No ☐	Cystic Fibrosis	Yes ☐	No ☐
Convulsions	Yes ☐	No ☐	Other Heart Disease	Yes ☐	No ☐	Other Illnesses	Yes ☐	No ☐

If you answered yes to any of the above, please explain _____

Pregnancy History

Did you take hormones during pregnancy? Yes ☐ No ☐
Did you take any drugs during pregnancy? Yes ☐ No ☐
Did you smoke during pregnancy? Yes ☐ No ☐
Did you drink any alcoholic beverages during pregnancy? Yes ☐ No ☐
Other:_____

Birth History

Circle one: Full term pregnancy Premature birth at_____ weeks Adopted - At what age?_____
Has he/she been told he's adopted? Yes ☐ No ☐ Where was child born?_____
Type of delivery_____ Obstetrician_____
Birth weight_____ Length_____ Head circumference_____ Apgars_____
Circle one: Breast fed Bottle fed How many ounces does he/she drink in a 24-hour period? _____
Any problems at birth? Please specify_____

Past Illnesses

Please mark date or frequency of illness or specify substance causing allergy

Roseola	_____	Asthma	_____	Rubella (German measles)	_____
Chicken Pox	_____	Heart Murmur	_____	Allergic to Medication	_____
Mumps	_____	Colds	_____	Allergic to Foods	_____
Tonsillitis	_____	Scarlet fever	_____	Allergic to Insect Bites	_____
Pneumonia	_____	Ear infections	_____	Other_____	
Convulsions	_____	Urinary infections	_____	Has child received desensitization shots? _____	

Surgeries / Hospitalizations

Please specify date or reason

Operations: _____
Hospitalizations: _____
Other:_____

Other

Is you child taking any medication on a regular basis? Yes ☐ No ☐
Please specify _____

Is there anything else about your child you feel we need to know to provide the best medical care for him/her?
Please specify _____

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