



NEW PATIENTS

Patient Name: _____

In order for us to be able to best serve your child and obtain all medical history possible, we require that **Custodial and/or Biological** parents or **Legal Guardian** attend your child's first appointment with us.

The forms attached will allow you to be able to let us know whom you would like to be able to bring your child to any future appointments.

We apologize for any inconvenience this may cause and greatly appreciate your cooperation.

Sincerely,
Davenport Pediatrics

We are very glad you have chosen Davenport Pediatrics for your child(s) new medical home. Kindly take a moment and let us know how you heard about us.

_____ Drive-by

_____ Friend: Whom can we thank for referring you? _____

Hospital: Heart of Florida _____ Nemours _____ Celebration _____

Other: _____

_____ Advertisement: Please Specify _____

_____ Other Medical Practice: Whom can we thank for referring you? _____

Internet: Google Search _____ Yelp Search _____

Other: _____

_____ Insurance Directory



☀ Welcome ☀

DAVENPORT PEDIATRICS PATIENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME: _____ NICKNAME: _____
Last Name First Name MI

ETHNICITY/ RACE: _____ PRIMARY LANGUAGE: English Spanish Other _____

SOCIAL SECURITY #: _____ - _____ - _____ SCHOOL: _____

HOME PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____ EMAIL ADDRESS: _____

HOME ADDRESS: _____ DATE OF BIRTH: ____/____/____ AGE: ____
MM DD YYYY

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____ SEX: M / F

MAILING ADDRESS IF DIFFERENT: _____

HOW DO YOU PREFER TO RECEIVE YOUR APPOINTMENT REMINDERS?: HOME PHONE CELL PHONE - CALL CELL PHONE - TEXT EMAIL
FOR TELEPHONE REMINDERS TO HOME OR CELL #'S, A MESSAGE WILL BE LEFT IF THERE IS NO ANSWER

PARENT OR GUARDIAN INFORMATION

NAME OF RESPONSIBLE PARTY/
PARENT OR GUARDIAN ACCOMPANYING CHILD: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____	SOCIAL SECURITY#: _____ - _____ - _____ RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: ____/____/____ SEX: M F <small>MM DD YYYY</small>
HOME PHONE: (____) _____ - _____ WORK PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____ EMAIL: _____	OCCUPATION: _____ EMPLOYER: _____ EMPLOYMENT STATUS: _____ BEST WAY TO CONTACT: _____
PATIENT LIVES WITH: _____ RELATIONSHIP TO PATIENT: _____	

NAME OF OTHER PARENT/ GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____	SOCIAL SECURITY#: _____ - _____ - _____ RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: ____/____/____ SEX: M F <small>MM DD YYYY</small>
HOME PHONE: (____) _____ - _____ WORK PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____ EMAIL: _____	OCCUPATION: _____ EMPLOYER: _____ EMPLOYMENT STATUS: _____ BEST WAY TO CONTACT: _____

EMERGENCY CONTACT INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PERSONS LISTED ABOVE)

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

HOME PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____ OTHER: _____

PREFERRED PHARMACY NAME/ LOCATION: _____ PHONE: (____) _____ - _____

CONSENT FOR TREATMENT

I certify that the information I have provided above is current and correct.

I hereby authorize DAVENPORT PEDIATRICS, P.A., its physicians and support staff to provide medical care to the patient named above. I voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician(s) in charge. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any examination or treatment received from DAVENPORT PEDIATRICS, P.A.

This consent is valid for the entire duration of my association with DAVENPORT PEDIATRICS, P.A. and may be relied upon by DAVENPORT PEDIATRICS, P.A. unless and until such consent is revoked in writing.

PRINTED NAME OF PARENT/ GUARDIAN: _____

SIGNATURE OF PARENT/ GUARDIAN: _____

DATE: _____
MM / DD / YYYY



DAVENPORT PEDIATRICS
CREDIT AND FINANCIAL POLICY

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE NUMBER: (____) ____ - _____

ADDRESS OF INSURANCE COMPANY: _____

NAME OF POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY ID #: _____ GROUP #: _____

POLICYHOLDER SOCIAL SECURITY #: _____ POLICYHOLDER DATE OF BIRTH: ____ / ____ / ____
MM DD YYYY

SECONDARY INSURANCE: _____ PHONE NUMBER: (____) ____ - _____

ADDRESS OF INSURANCE COMPANY: _____

NAME OF POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY ID #: _____ GROUP #: _____

POLICYHOLDER SOCIAL SECURITY #: _____ POLICYHOLDER DATE OF BIRTH: ____ / ____ / ____
MM DD YYYY

CREDIT AND FINANCIAL POLICY

Davenport Pediatrics, P.A. wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or to a member of your household/family.

Insurance

Co-payments are due and payable at the time of visit. As a courtesy to you, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

You shall also be responsible for any claim denied by the insurance company. The insurance company may deny a claim for any of the following reasons:

- (1) Davenport Pediatrics is an out-of-network provider or Davenport Pediatrics does not participate with your insurance company.
- (2) The claim is rejected because there was no insurance coverage at the time of service.
- (3) Davenport Pediatrics was not the assigned primary care physician for the patient or for your insurance company.
- (4) The procedure/ lab work done is not a covered service or benefit by your insurance company.
- (5) Your insurance company is still waiting for additional information that they have requested from the parent/ guardian of the patient.
- (6) Your insurance company has already made the payment and the remaining balance is your responsibility.
- (7) Only hospital charges are covered by your insurance company.

There may be other reasons that the insurance company may reject a claim filed on your behalf. If there are any questions regarding their decision(s), you must contact your insurance company immediately.

Cash Account

If proof of insurance is not provided, your account will be considered a cash account and payment in full of all charges will be required at the time of service.

At this time, even if you are able to subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will **not** be able to bill the charges to your insurance company for you.

Billing

The billing statement you receive will show patient balances due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement.

Appointments

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hour notice, consider that another child could have been seen at that time. We reserve the right to charge a \$25 cancellation or 'no show' fee. In order to see each patient on time, your appointment may need to be rescheduled if you arrive 10 minutes or more late.

Returned Checks

You would also be responsible for the \$35 returned check fee that the bank would charge in the event that the personal check issued by you is returned to us for any reason. You must also consult with your financial institution for any other fees they might charge you.

ASSIGNMENT OF HEALTH INSURANCE BENEFITS

I hereby authorize DAVENPORT PEDIATRICS, P.A. to collect on my behalf any insurance/ medical benefits payable to me for the service(s) they have provided and assign to them the payment thereof. I authorize and assign the payment of any insurance/ medical benefits applicable to the service(s) cited on the claim form to DAVENPORT PEDIATRICS, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is considered as valid and effective as the original.

I understand that this assignment does not relieve me of any responsibility I may have for any payment of charges that are not covered by the insurance company. I understand that I may be held responsible for any or all unpaid charges on this account.

I have read and understand the financial policy of DAVENPORT PEDIATRICS, P.A. and I agree to be bound by its terms I also understand and agree that such terms may be amended by DAVENPORT PEDIATRICS, P.A. at any time.

PRINTED NAME OF PARENT/ GUARDIAN: _____

SIGNATURE OF PARENT/ GUARDIAN: _____ DATE: _____



DAVENPORT PEDIATRICS
CONSENT TO THE USE AND
DISCLOSURE OF PROTECTED HEALTH INFORMATION

PROTECTED HEALTH INFORMATION

Information about your child's health is called "protected health information." It includes any information that DAVENPORT PEDIATRICS, PA receives or creates that identifies (or could identify) your child and deals with your child's physical and/ or mental health, and any medical care we provide your child and/or payment for such medical care.

DAVENPORT PEDIATRICS, P.A. understands the importance of privacy and is committed to maintaining the confidentiality of your child's medical information. We make a record of the medical care provided to your child and may receive other medical records from others. We use these records to provide and enable us and other healthcare providers to provide quality medical care, to obtain payment for medical services provided to your child and to enable us to meet our professional and legal obligations to properly operate our medical practice. We have a "Notice of Privacy Practice" (the "Notice"). The Notice describes in great detail how we might use or disclose protected health information. The notice also discusses your rights and our duties with respect to protected health information. You have the right to review the Notice before signing this consent. This notice is available on our website @ www.davenportpediatrics.com or you may request a copy from our front office staff.

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I am consenting to DAVENPORT PEDIATRICS, P.A.'s use and disclosure of my child's health information in order to carry out treatment, payment or health care operation.

I understand that I have the right to revoke this authorization at any time by notifying DAVENPORT PEDIATRICS, P.A. in writing. However, if I do revoke this authorization, my revocation would not have any effect on action(s) previously taken in reliance on my prior consent.

I understand that I have the right to request that DAVENPORT PEDIATRICS, P.A. restrict how my child's protected health information is used or disclosed for purpose of treatment, payment or health care operations. However, I also understand that DAVENPORT PEDIATRICS, P.A. is not required to agree to any restriction I requested.

I understand that DAVENPORT PEDIATRICS, P.A. has the right to amend their privacy practices at any time in the future. I understand that after an amendment is made by DAVENPORT PEDIATRICS, P.A., the revised privacy practices will apply to all protected health information maintained, regardless of when it was created or received.

I acknowledge that I have been presented with a copy of DAVENPORT PEDIATRICS, P.A.'s Notice of Privacy Practices and have been provided an opportunity to review it. I am aware that I may request a copy of the Notice of Privacy Practices to keep in my possession.

RESPONSIBLE PARTY/ PARENT OR GUARDIAN: _____ PRINTED NAME

RESPONSIBLE PARTY/ PARENT OR GUARDIAN: _____ SIGNATURE DATE: _____ MM/DD/YYYY

Name(s) of patient(s) in practice:

NAME OF CHILD: _____ DATE OF BIRTH: _____ / _____ / _____
MM DD YYYY

NAME OF CHILD: _____ DATE OF BIRTH: _____ / _____ / _____
MM DD YYYY

NAME OF CHILD: _____ DATE OF BIRTH: _____ / _____ / _____
MM DD YYYY

NAME OF CHILD: _____ DATE OF BIRTH: _____ / _____ / _____
MM DD YYYY



DAVENPORT PEDIATRICS

INITIAL PEDIATRIC HISTORY FORM

Last Name	First Name	MI	Date of Birth (Month, Date, Year)
Mother/ Guardian		How many brothers/ sisters?	
Father/ Guardian		Who does the patient live with?	
Primary Care Physician/ Pediatrician		Other doctors involved with patient's care?	

A. BIRTH HISTORY

Birthplace: _____ Birth weight: _____ Birth Length: _____
 Was the pregnancy normal? No Yes Other _____ Was the delivery normal? No Yes Other _____
 Was the baby full term? No Yes Other _____ Any nursing problems? No Yes Other _____

B. GROWTH AND DEVELOPMENT

At what age did the child:

first sat-up Precocious Average Other _____ first crawled Precocious Average Other _____
 first rolled Precocious Average Other _____ first walked Precocious Average Other _____
 first talked Precocious Average Other _____ toilet trained Precocious Average Other _____

School History: Current School Grade: _____ School Name: _____
 Academic Performance: Not in School Remedial/ Special Ed Below Average Average Above Average
 School Problems: _____ Attends special school or classes: _____
 Discipline or behavior problems: _____
 Ever seen by a psychologist, speech therapist, or special teachers: _____

C. PAST MEDICAL HISTORY

Any problems with: Sleeping: No Yes Other _____ Bedwetting: No Yes Other _____
 Weight/Height: No Yes Other _____ Nail Biting: No Yes Other _____
 Nightmares: No Yes Other _____
Diet: Nursed: No Yes Other _____ Bottled fed: No Yes Other _____
 Colic problems: No Yes Other _____ Special diets No Yes Other _____

Contagious Diseases: (At what age) Chicken Pox: _____ Scarlet Fever: _____ Any Other: _____

Was your child ever diagnosed with any of the following? (At what age)

Seizures: No Yes Age _____ Asthma: No Yes Age _____
 Bronchitis: No Yes Age _____ Pneumonia: No Yes Age _____
 Ear Infections: No Yes Age _____ Any Other: _____

Please explain any YES answer in detailed description in the box provided.

Has the patient ever had any surgery or been hospitalized?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<u>Surgeries/ Serious Injuries</u> (Where, Why)	<u>Dates</u>	<u>Hospitalizations other than surgery</u> (Where, Why)	<u>Dates</u>
Has the patient had any problems with anesthesia?					
Is the patient currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>
Does the patient have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	<input type="checkbox"/> No <input type="checkbox"/> Yes				

FAMILY HISTORY: Please indicate if parents, brothers, and/ or sisters have had any of the following conditions:

Condition	Relation to Patient	Condition	Relation to Patient
Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____		Kidney Problems <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____	
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____		Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____	
Heart Disease <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____		TB <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____	
Convulsions <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other _____		Other _____	

GENERAL INFORMATION: Has your child had any unusual problems with the following?

Head: No Yes Other _____ Stomach: No Yes Other _____
 Eyes: No Yes Other _____ Kidneys: No Yes Other _____
 Ears/ Nose/ Throat: No Yes Other _____ Bladder: No Yes Other _____
 Chest/ Heart/ Lungs: No Yes Other _____ Skin: No Yes Other _____
 Bones/ Muscles/ Joints: No Yes Other _____ Blood: No Yes Other _____

D. IMMUNIZATIONS: Did you bring a record of immunizations of your child? No Yes Other _____

E. Any special comments about your child? _____

Person Completing This Form/ Relationship to Patient

Reviewed by Provider

Date



DAVENPORT PEDIATRICS
MEDICAL TREATMENT
AUTHORIZATION AND CONSENT FORM

MEDICAL TREATMENT AUTHORIZATION AND CONSENT

This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult(s) to arrange for routine or emergency medical care for the child when either the parents or legal guardians are unable to accompany the child and approve or consent to the child's medical care.

This is extremely important because medical care cannot be provided to the child without the approval or consent by either the child's parents or legal guardians, unless there is written consent authorizing another adult to approve or consent to the child's medical care.

DATE: _____
MM / DD / YYYY

I, _____, parent or legal guardian of _____,
(Name of Parent or Legal Guardian) (Name of Child)

hereby give authorization to the following person(s) to accompany my child and to approve or consent to any medical care or treatment to be provided by DAVENPORT PEDIATRICS, P.A., its physicians and support staff to my child.

Name	Relationship to Child
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

(Signature of Parent/ Guardian)

Persons on the above list must have proper identification (ID) to have the patient treated.

103 Park Place Blvd
Davenport, FL 33837
Phone: 863-421-1855
Fax: 863-421-2624

Maria Cristina Khan, MD, FAAP
Edwin Michael C. Sia, MD, FAAP



Authorization for Release of Protected Health Information

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient(s) Name: _____ Date of Birth: _____

To: Davenport Pediatrics PA
103 Park Place Blvd
Davenport FL 33837
Fax: 863-421-2624

FROM: Organization to release the information:

Specific description of Information {including date(s)}:

(Check one)

- All Records (including Mental Health/Sexual Abuse/HIV)
- All Records (excluding Mental Health/Sexual Abuse/HIV)
- Records Within the Following Date Range: from _____ to _____
- Immunization record only
- Last Well Child Visit/Physical/Growth Chart/Immunization Chart
- Sexual Abuse Only
- HIV only
- Mental Health Records (Including ADHD) Only
- Other: Please specify _____

Section B: Must be completed for all authorizations

The patient or patient's representative must read the following statements:

1. I understand that this authorization will expire on _____ (or one year from date of signature).
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing; but, if I do, it would not have any effect on any actions they took before they received the revocation.
3. If a health care provider is receiving these records, the information will be used for continuity of care purposes only.
4. I understand that I may have a copy of this form at any time when requested.
5. I understand that my health care and payment for my health care will not be affected by signing this form.

X _____
Signature of patient or patient's representative Phone Number Date

(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to patient: _____