Pediatric Associates of Julington Creek

Patient Information

Office Use Only

Today's Date: ___________________________Referred By: ____________________________

PATIENT INFORMATION:

(Please Print)

Full Legal name: ____________________________________ Preferred Name: _____________

Race: Caucasian (white) American Indian African American (black) Hispanic Biracial Asian

Oriental Other Unknown

Date of Birth: ________________ SS# ______-_______-________ Sex: Male Female

Home Address: ________________________________City: ________________State: ______

Zip Code: __________ County: ____________________

Mail to Address: ________________________________City: ________________State: ______

(If different)

Zip Code: __________ County: ____________________

Primary Phone Number: (________) ________-__________

Secondary Phone Number: (________) ________-__________

Preferred Language: ____________________ E-mail: __________________________________

Name of School/Daycare: ____

PARENT / GUARDIAN INFORMATION:

Father: _____________________________DOB: ____________SS# ______-_______-________

Employer: ________________________________

Work # (________) ________-__________ Cell # (________) ________-__________

Address: ________________________________City: ________________State: ______

(If different)

Zip Code: __________ County: _________________

Pediatric Associates of Julington Creek
Patient Information Cont.

Office Use Only

Mother: ______________________________DOB: ___________SS# ______-_______-________

Employer: _________________________________

Work # (________) ________-__________ Cell # (________) ________-__________

Address: _________________________________City: ________________State: ______

(If different)

Zip Code: __________ County: _________________

Emergency Contact:

Name: ____ Relationship_________________

(Other than PARENT)

Address: _________________________________City: _____________________ State: _______

Zip Code: _____________

Phone #: (_______) _______-________ Cell #: (_______) _______-________

GUARANTOR INFORMATION:

Name: __________________________________ Patient Relation to Guarantor: ____________

DOB: ___________ SS# ______-______-_______ Primary Phone: (_______) _______-________

Address: _________________________________City: ______________State: ______

Zip Code: ______________

Insurance Company Name:____

Phone Number: (______) ________-________

Identification Number: _________________________ Group Number: ____________________

Effective Date: ______________________

Pediatric Associates of Julington Creek

PATIENT HISTORY QUESTIONAIRE

MOTHER'S PREGNANCY:

Age: _______ Any Problems? ____

Medication's? ____

During Pregnancy was there any:

Smoking: **Y/N** Alcohol: **Y/N** Illegal Drugs **Y/N** Infections **Y/N**

Was baby:

Early: _________ On Time: _________ Late: _________? Type of delivery? ________________

BIRTH:

Weight: _____________ lbs _____________oz Length: _____________inches

APGAR Scores: __________________

Problems with baby:

Breathing: _______ Jaundice: ________ Bili Lights: ________ Others: ________________

FEEDING AND NUTRITION:

Colic or feeding problems within the first three months?

____

Breast Fed: **Y / N** Number Of months: _________________ Supplemented? **Y / N**

Formula: **Y / N** Current Brand: ____

Age baby food started: ______________________________

ALLERGIES:

Medicine: ___________________ Animals: _____________________ Food: ___________________

IS CHILD ON MEDICATIONS? ____

IMMUNIZATIONS: Up to Date? **Y / N**

PAST MEDICAL HISTORY:

Chronic medical problems?

____

____

____

Hospitalizations?

____

____

____

Surgeries/Serious Injuries? (Where-When-Why)?

____

____

____

DOES YOUR CHILD HAVE OR HAD ANY OF THE FOLLOWING?

_____ Asthma/Wheezing	_____ Fractures	_____ Freq. Ear Infections	_____Urinary Infections
_____ Allergies	_____ Seizures	_____ Chicken Pox	_____ Joint Problems
_____Anemia	_____ Eczema	_____ Bleeding Disorder	_____ Blood Transfusion

PROBLEMS OR CONCERNS WITH……

Hearing _____ Vision_____ Speech_____ Development_____ Other_____

DEVELOPMENT AND BEHAIVOR:

At what age did your child:

Sit alone ____________ Walk____________ Used Sentences____________ Toilet Trained____________ Bicycled ____________

Learning Problems? **Y/N** ____

Behavioral Problems? **Y/N** ____

Bedwetting? **Y/N** Sleep Problems? **Y/N** Nail Biting? **Y/N** Smoking? **Y/N**

FAMILY PROFILE:

PARENTS: Married **Y / N** Separated **Y / N** Divorced **Y / N** Smokers **Y / N**

Father's age: _______ Highest School Grade? _______________________

Health? ____

Mother's age: _______ Highest School Grade? ______________________

Health? ____

PATIENT'S siblings (name and age):

____

____

____

FAMILY MEDICAL HISTORY:

Check the box to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters, and grandparents) state your relationship in the relationship box. *F- Father, M- Mother, B- Brother, S- Sister, MF- Mother's Father, MM-Mother's Mother, FM- Father's Mother, FF- Father's Father, MS- Mother's Sister, MB- Mother's Brother, FS- Father's Sister, FB- Father's Brother.*

Asthma_____________ **Allergies**_____________ **Migraines**_____________

Anemia_____________ **Stroke**_____________ **High Blood Pressure** _____________

Heart Disease_____________ **Cholesterol Problems**_____________ **Diabetes**_____________

Arthritis_____________ **Drug/Alcohol Problem**_____________ **SIDS**_____________

Cancer (Type) ____________________ **AIDS**_____________

Early deafness _____________ **Tuberculosis**_____________

Mental Retardation_____________ **Epilepsy/Seizures**_____________

Cystic Fibrosis____________ **Birth defects** __________ **Early Death**(less than 50) ___________

CURRENT PHARMACY:

Preferred: ____

(Name & Location)

Phone Number: (______) ______-_________

Alternate Pharmacy: ____

(Name & Location)

Phone Number: (______) ______-_________

QUESTIONS/CONCERNS:

PEDIATRIC ASSOCIATES OF JULINGTON CREEK
1631 Racetrack Rd. Suite 101
Jacksonville, FL.32259
MARY ANN GARCIA M.D
VICTOR LUZ M.D

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I do hereby give my consent to: ____
____
____
____

to disclose and give copies of information to:

Pediatric Associates of Julington Creek
1631 Racetrack Rd. Suite 101
Jacksonville, Florida 32259
Phone: (904)230-7977 Fax: (904)230-7979

Including the diagnosis and records of any treatment or examination rendered to my child:

______________________________ ____________________
Patient Name (print) **Date of Birth**

Specifically, the following reports will be included:
___Progress Notes __X-ray reports __ Laboratory/ Pathology Reports
___ Consultation Reports ___Immunization Record __Hospital Records
___ Other (specify) ___________________

___(Initials) I ____ DO (or) ____ DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnoses, prognosis and treatment and/or HIV (AIDS) testing and/or results or such disclosure shall be limited to the following specific types of information:
____

Purpose of disclosure: ____ Medical Care ____ Other________________________________

This authorization shall be valid for 365 days from the date of signature. The patient can revoke the authorization in writing at any time prior to the expiration date. The patient agrees that a photocopy of this authorization may be considered valid. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damage resulting from the lawful release of my Protected Health Information.

______________________________________ ______________________

Signature of parent of Legal Guardian Date

_____________________________________ ______________________

Relationship to Patient Witness signature and date

EMERGENCY CARE/CONSENT FOR TREATMENT

Patients Name ________________________________Date of Birth________________

I hereby give permission to the physicians of Jacksonville Pediatrics to direct any emergency medical treatment to my children during my absence.

It is understood that they will make every effort to contact me in case of medical emergency. It is further understood that if they are unable to contact me, that I give them this permission with my full consent.

If hospitalization is necessary, I direct the physicians of Jacksonville Pediatrics to arrange admission. I will be financially responsible for all hospital expenses.

For non-urgent care (well care, immunizations, minor illnesses, etc) it is necessary for you to list the individuals to whom you have given permission to bring the child in for care.

Please list them below:

Name	**Relationship to Child (aunt, neighbor, etc)**
________________________________	____________________________________
________________________________	____________________________________
________________________________	____________________________________
________________________________	____________________________________
________________________________	____________________________________

Date: __________________ Signed: ____

Witness: ____________________________________ Date ____________________

Pediatric Associates of Julington Creek

Medical Photography Release/Approval:

This practice is strongly dedicated to the use of the most advanced technologies available giving and documenting your medical care. To this end, we have invested in electronic medical records. This means that all items traditionally in a paper format will be obtained, stored and cataloged digitally. This record will also include the digital photo of your child(ren) for identification by our staff. Any lesions, procedures, or other items which may be documented visually, will also be stored and reproduced in this manner. If you have no objection to the use of these photos we would greatly appreciate your signature below.

I hereby authorize Pediatric Associates of Julington Creek and it's Representatives to obtain and reproduce photographs of my child(ren)'s likeness(es) for purposes of medical records. I also approve of the use and reproduction of clinical photos for referral, coding, charting, and education purposes.

_______________________________________ _______________________________

Signature of Parent or Legal Guardian | Date

_______________________________________ _______________________________

Print Name of Parent or Legal Guardian | Legal relation to child(ren)

List Name(s) of child(ren) covered in release

____

____

____

____

____

Mary Ann Garcia, MD

Victor Luz, MD

1631 Race Track Road, Suite 101

Jacksonville, Fl 32259

PEDIATRIC ASSOCIATES OF JULINGTON CREEK

PATIENT'S HIPAA ACKNOWLEDGEMENT

CHART # ____________
(for office use only)

PATIENT NAME: ____________________________________ DOB: ____________________

I HAVE READ THE "NOTICE OF PRIVACY PRACTICES" FOR PEDIATRIC ASSOCIATES OF JULINGTON CREEK.

____ _________________________
SIGNATURE DATE

Pediatric Associates of Julington Creek

Billing Policy

We are committed to providing you with the best possible care and we are ready to discuss our professional fees with you at any time. Your understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy or what your responsibility is.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AND DISCOVER

MINORS WHO ARE SEEN IN OUR OFFICE

An adult must accompany all minors and full payment is due at the time of service. If your child is old enough to come to our office on his/her own they also will be required to pay at the time of service.

REGARDING BILLING

It is the policy of this office not to bill or extend credit. You are required to pay at the time of service. We cannot hold checks. If you have an emergency or a problem paying please call our billing department and they will discuss arrangements with you.

REGARDING INSURANCE

If we accept your insurance, you are responsible for any deductibles, coinsurance or co-pays at the time of service. Insurance policies with required co-pays must be paid at the time of service or we may charge YOU for the full amount of the visit. If your insurance carrier changes, it is your responsibility to notify us when checking in. If you fail to do so, you may then become responsible for the full amount of the visit. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

The guardian who brings the child in is responsible for payment. Divorce settlement/financial responsibility for the child issues are to be worked out between the parents.

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered not covered by insurance. I have read all the information above and understand it to the best of my knowledge. I will notify you of any and all future changes.

Signature of Parent/Guardian___________________________________ Date_______________

Pediatric Associates of Julington Creek

Privacy Policy Notification

Pediatric Associates of Julington Creek is committed to protecting the privacy of our patients. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Pediatric Associates of Julington Creek has created a Privacy Policy. The purpose of this notification is to familiarize yourself with the existence of our policy as well as give you an overview of its contents. The full written policy is available to you on request.

HIGHLIGHTS

Your Rights: You have a right to inspect and copy your protected health information. You have a right to request a restriction of your protected health information. You have the right to have your physician amend your health information. You have a right to receive an accounting of disclosures of your protected health information.

Pediatric Associates of Julington Creek will use your private information in a variety of ways to facilitate your care. Some of these uses require your written consent and some do not. Private information (termed Protected Health Information or PHI in HIPPA), includes anything which individually might identify you (Name, SSN, diagnoses, etc)

Pediatric Associates of Julington Creek may use your PHI without written consent to communicate with emergency rooms, hospitals, specialists, lab and x-ray facilities, and other facilities involved in the current treatment of the patient. In addition, Pediatric Associates of Julington Creek will routinely use PHI in the submission of billing to insurance companies. Also, any release required by law (mandatory notification of contagious disease to the health department, issues involving abuse or neglect, adverse drug and treatment reports to the FDA, issues involving criminal activity to law enforcement, or other releases required by law) may take place.

Pediatric Associates of Julington Creek requires your written consent to release PHI to parties other than those listed above. This includes release to relatives other than immediate caregivers, to attorneys, to employers, to life insurance or disability insurance carriers, to research projects, or any others not listed previously.

Pediatric Associates of Julington Creek does have business relationships with some companies who might periodically have access to your PHI. These include our attorneys, practice management consultants, computer system consultants and others. The purpose of these situations is for these entities to advise us, internally, on our practice operations. Pediatric Associates of Julington Creek maintains a contractual agreement with these entities which restricts their use of private information to their business relationship with us.

Pediatric Associates of Julington Creek

Privacy Policy Notification Cont.

Pediatric Associates of Julington Creek does increasingly use computer systems to transmit private information. This is largely to transmit claim and referral information with insurers and to exchange private information with other health care facilities. HIPPA mandates the secure electronic transmission of private information and we are in compliance with those requirements.

Pediatric Associates of Julington Creek does use PHI during the day to day operations of the office. While certain uses of PHI (such as calling you by name in the waiting room) are acceptable, others (such as a person overhearing a telephone call regarding your case) are not. From afterhours security systems, to keeping charts out of patient areas, to minimizing the volume of our conversations, to shutting exam room doors and others, we are committed to preventing inadvertent disclosures.

Your feedback about how we are doing in this or any other area is strongly encouraged.