Windermere Pediatrics

For all Your Growing Needs!

Child's name_____ D.O.B._____

Welcome to our practice. We are dedicated to providing quality personal health care to each of our patients. In order to facilitate your first visit, please complete paperwork prior to your scheduled appointment. Due to the additional time our staff requires to prepare your chart for your first visit, we ask that you arrive 30 minutes prior to your scheduled appointment. Failure to arrive within this time will result in rescheduling of your appointment. Please have your completed paper work, your child's insurance card and picture identification available when you arrive for your appointment.

There will be a $50.00 charge for all appointments that are not kept or are cancelled with less than 24 hours notice.

AS a courtesy to our patients, we will verify your insurance benefits prior to or on your first visit. This will indicate covered services and your financial responsibility. Co-payments or coinsurance's are due at the time services are rendered. Failure to provide you co-payments upon each visit will result in rescheduling your appointment. For your convenience we accept cash, personal checks, MasterCard, Visa, Discover, and American Express. **A $35.00 charge will be applied to all returned checks.**

Our physician cannot assume any responsibility for you medical care until you have become an established patient. Therefore, no prescriptions, diagnostic testing or treatment can be given at your initial visit.

Thank you for choosing our practice to meet your medical needs. Our goal is to provide you with the best medical care available in a relaxed and warm atmosphere.

Signature_____ Date_____

Patient Information

Please answer all questions fully

Date:

Account Number:

Windermere Pediatrics
7635 ASHLEY PARK CT
SUITE 501
ORLANDO, FL 32835-6196
Phone: (407) 297-0080 Ext. Fax: (407) 295-3080

Patient						
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Race	Home Phone
Mailing Address	City	State	Zipcode	Marital Status		
Employer	City	State	Zipcode	Work Phone		

Responsible Party					
Name (Last, First ,MI)	Social Security	Birthdate	Sex	Home Phone	
Address	City	State	Zipcode	Marital Status	
Employer	City	State	Zipcode	Work Phone	

Primary Provider	Referring Provider	Referring Address	Phone	Fax

Insurance Information				
Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Second Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Third Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay

Emergency Contact Information			
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Please List Additional Medical Information

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____ Date: / /

(Signature of insured or authorized person, patient or parent if minor)

Windermere Pediatrics

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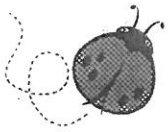
ATTENTION PARENTS



You must notify us of any changes in your insurance

This is the only way to ensure all lab tests and claims are filed/or billed correctly.

It is the parent's responsibility to be sure the correct information is in your child's chart.

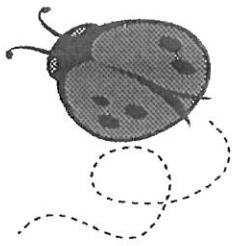
Any charges accrued due to incorrect information will be bill to you, the parent.

Patient Name: _____

Ins Company Name: _____

Ins Company ID#: _____

Laboratory Name: _____



Windermere Pediatrics

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Saturday Office Visits Waiver

Dear Patients,

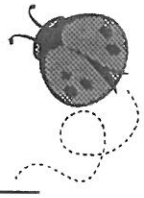
The operating hours of Windermere Pediatrics **DO NOT** include Saturdays.

If you feel your child has an urgent medical need on a Saturday, you may contact our office and arrange to have your child seen by the physician on call.

It is important for you to note that **an additional after hour charge of $30.00 is billed to you child's account for this service.**

Some insurance carriers may deny this claim as non-urgent or not covered through your plan.

If your child is seen in our office on Saturday, you will be financially responsible for the additional $30.00 charge.



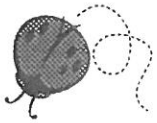
Please sign your acknowledgement and acceptance below.

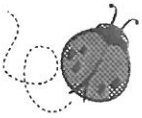
Signature_____ Date_____

Patient Name_____ Date of Birth_____

Windermere Pediatrics

For all Your Growing Needs!





Patient Consent

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In connection with the medical services my child is receiving from Windermere Pediatrics, I consent to and authorize the physicians and their staff to use and disclose any and all Protected Health Information (PHI) necessary to carry out treatment, Payment and healthcare operations (TPO) related to my child's medical care. I understand the Notice of Privacy Practices is available from the receptionist and that it offers a more complete description of uses and disclosures. This office reserves the right to review and change our Notice of Privacy Practices at any time.

Windermere Pediatrics may call my home or office and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my child's healthcare.

I have the right to request that this practice restricts how they use of disclose my protected health information (PHI) to carry out treatment, payment, and healthcare options (TPO). However this office is not required to agree to my request restrictions but if they do the office is bound by this agreement.

By signing this form I consent to the use and disclosure of my child's PHI to carry out treatment, payment and health care operations (TPO). This consent may be revoked by submitting a request in writing. If I decline to sign this consent, this practice may decline to provide my treatment.

Printed Patient Name: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____

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Welcome! Please take a few moments to tell us how you heard about Windermere Pediatrics.

Patient Name _____

☐ My Doctor _____ ☐ Friend/Family _____

☐ Our Website

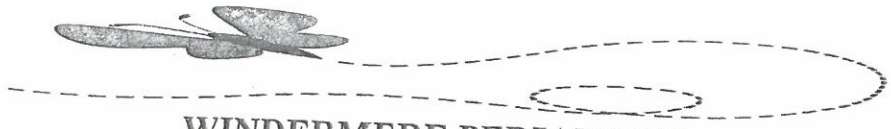
☐ Yellow Pages

☐ Hospital
- ☐ Florida Hospital
- ☐ Arnold Palmer/Winnie Palmer
- ☐ Health Central
- ☐ Other _____

☐ Magazine Ad
- ☐ Playground
- ☐ Tu Revista
- ☐ South West Bulletin
- ☐ Other _____

☐ Windermere Pediatrics Brochure or other promotional item

☐ Other _____



WINDERMERE PEDIATRICS
7635 ASHLEY PARK CT. SUITE 501
ORLANDO, FL. 32835

Ginny Guyton, MD
Marc Feldman, MD
Denise Serafin, MD
Amber Eastwood ARNP
Larissa Negron, MD
Maryann Dunn, ARNP

Telephone #: 407-297-0080
Fax #: 407-295-3080

MEDICAL RECORDS RELEASE

I hereby authorize the personal health information pertaining to my child to be obtained or released. I understand that these records may contain information including psychological, psychiatric, alcoholic substance abuse, HIV/AIDS results, testing and/or other information regarding diagnosis and treatment.

Patient's Name: _____
Patient's Date of Birth: _____

Windermere Pediatrics will:

OBTAIN RECORDS FROM:

From: _____
Address: _____
City: _____
Phone #: _____
Fax #: _____

RELEASE RECORDS TO:

To: _____
Address: _____
City: _____
Phone #: _____
Fax #: _____

Reason for records: _____

Please check the specific records needed:

_____All Medical Records
_____Pt. History/Physical; Last 3 Office Notes; Growth Chart; Immunization Record
_____Lab Results
_____Other

Signature of Parent/Guardian _____

Date: _____

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

_____

_____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When	_____
Frequent ear infections	☐ Yes	☐ No	Explain	_____
Problems with ears or hearing	☐ Yes	☐ No	Explain	_____
Nasal allergies	☐ Yes	☐ No	Explain	_____
Problems with eyes or vision	☐ Yes	☐ No	Explain	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain	_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain	_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain	_____
Blood transfusion	☐ Yes	☐ No	Explain	_____
Frequent abdominal pain	☐ Yes	☐ No	Explain	_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain	_____
Bladder or kidney infection	☐ Yes	☐ No	Explain	_____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain	_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When	_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain	_____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain	_____
Frequent headaches	☐ Yes	☐ No	Explain	_____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain	_____
Diabetes	☐ Yes	☐ No	Explain	_____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain	_____
Any other significant problem	☐ Yes	☐ No	Explain	_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain	_____

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