



Windermere Pediatrics  
For All Your Growing Needs!

Child's Name

Date of Birth

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 paperwork, your child's insurance card and picture identification available when you arrive for your appointment.

All patients under the age of 18 years must be accompanied by a parent or legal guardian.

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. Please know your Insurance Plan details. Co-payments, Deductibles or Coinsurances are due at the time services are rendered. Failure to provide your Co-payment 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 your medical care until you have become an established patient. Therefore, no prescriptions, diagnostic testing or treatment can be given before your initial visit.

Signature

Date

**Windermere Pediatrics**  
7635 Ashley Park Ct Suite 501  
Orlando, FL 32835  
Phone: 407-297-0080  
Fax: 407-295-3080

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F Race: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Apt# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**RESPONSIBLE PARTY**

Parent/Legal Guardian Name: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F Race: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Apt# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company: \_\_\_\_\_  
Policy ID: \_\_\_\_\_ Group: \_\_\_\_\_  
Subscribers Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Please Release: I certify the information I have provided is correct. I authorize the release of medical information necessary to process 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 FEES, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due. Permit a copy of this release to be used in place of the original.

Signature

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, ages, and where they live. \_\_\_\_\_

What is the child's living situation if not with both biological parents?

Lives with adoptive parents  Joint custody  Single custody

Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? \_\_\_\_\_

## Birth History Don't know birth history

Birth weight \_\_\_\_\_ Was the baby born at term? \_\_\_\_\_ OR \_\_\_\_\_ weeks

Were there any prenatal or neonatal complications?

Yes  No Explain \_\_\_\_\_

Was a NICU stay required?  Yes  No Explain \_\_\_\_\_

During pregnancy, did mother

Use tobacco  Yes  No

Drink alcohol  Yes  No

Use drugs or medications  Yes  No  Used prenatal vitamins

What \_\_\_\_\_ When \_\_\_\_\_

Was the delivery  Vaginal  Cesarean If cesarean, why? \_\_\_\_\_

Was initial feeding  Formula  Breast milk How long breastfed? \_\_\_\_\_

Did your baby go home with mother from the hospital?

Yes  No Explain \_\_\_\_\_

## General DK = don't know

Do you consider your child to be in good health?  Yes  No  DK Explain \_\_\_\_\_

Does your child have any serious illnesses or medical conditions?  Yes  No  DK Explain \_\_\_\_\_

Has your child had any surgery?  Yes  No  DK Explain \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No  DK Explain \_\_\_\_\_

Is your child allergic to medicine or drugs?  Yes  No  DK Explain \_\_\_\_\_

Do you feel your family has enough to eat?  Yes  No  DK Explain \_\_\_\_\_

## Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Nasal allergies  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Asthma  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Tuberculosis  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Heart disease (before 55 years old)  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

High cholesterol/takes cholesterol medication  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Anemia  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Bleeding disorder  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Dental decay  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

Cancer (before 55 years old)  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

## Biological Family History (Continued from front side.) DK = don't know

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

## Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sleep problems; snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Has had first period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of first period _____	
Any other significant problem _____				

**This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.***

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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## ATTENTION PARENTS

**\*You must notify us of any changes in your insurance, phone numbers and address.**

This is the only way to ensure all lab tests and claims are filed/or billed correctly. Updated phone numbers allows us to call you regarding test results and appointment confirmations.

**\*It is the parents/guardians responsibility to be sure the correct information is in your child's chart.**

Any charges accrued due to incorrect information will be billed to you, the responsible party. Insurance companies need to be billed in a timely period in order for them to cover services the patient receives.

**\*Please know the details of your Health insurance plan**

It is your responsibility to understand your health insurance policy benefits and obligations; this includes your financial obligations for the services provided by the participating physician, and to obtain prior authorization when necessary. The parent/ policy holder is responsible for any and all charges that the insurance does not pay. Payment is due at the time services are rendered unless otherwise discussed. Intentionally not paying your bill is unlawful and balances will be sent to Collections after a period of time. The responsible party that brings the child to the appointment will be liable for any charges that day and any balances on the account no matter the family dynamics. We do not get involved with personal relationship matters.

**\*It is the parents/guardians responsibility to know the date and time of their child's appointment.**

We try our best to give reminder/courtesy calls for upcoming appointments. Unfortunately, there are times that we may not be able to give confirmation calls. It is ultimately the parent's responsibility to confirm, cancel or reschedule their appointments. Missed appointment fees will not be waived due to not receiving a confirmation call.

**\*Saturday Office visits**

If you feel your child has an urgent medical need on a Saturday, you may contact our office and ask about availability to have your child seen by the physician on call. Appointments are not always available. If need be, we may re direct you to an Urgent care or Emergency services.

It is important for you to note that an additional after hour charge of \$30.00 is billed to your 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.

Signature

Date

# AUTHORIZATION TO ACCOMPANY PATIENT

I, \_\_\_\_\_, give permission to all parties listed below  
*(Name of Guardian)*  
to accompany my child, \_\_\_\_\_  
*(Patient's Name)* *(Date of Birth)*

and authorize treatment for my child in accordance with the office policies of Windermere Pediatrics. This includes bringing the child into the office, providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, and responsibility for relaying any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all co pays, deductibles or coinsurances.

The following are permitted to accompany patient and MUST SHOW PHOTO ID AT CHECKIN

\_\_\_\_\_  
Name Phone Relationship to Patient

\_\_\_\_\_  
Name Phone Relationship to Patient

\_\_\_\_\_  
Name Phone Relationship to Patient

\_\_\_\_\_  
Parent/Legal Guardian Signature Date

# HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protect health information about you. The notice contains a Patient's Right section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice mat change. If we change our Notice, you may obtain a revised copy by contacting our office, or going on our Website.

You have the right request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the uses of their information
- The Patient may revoke the Consent in writing at any time and all future disclosures will then cease.

The practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

This HIPPA consent was signed by:

---

Parent/Legal Guardian Signature

---

Date

# CANCELLATION, MISSED APPOINTMENT & LATE POLICY

## Cancellation of an Appointment

We strive here at Windermere Pediatrics to provide you and your child with convenient, accessible, high quality medical care. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive timely for all scheduled appointments or cancel the appointment 24 hours in advance. This policy allows us to make better use of our available appointments for those patients in need of medical care. Failure to cancel or re-schedule an appointment within 24 hours of the scheduled appointment time will result in a fee of \$75 for a missed appointment.

## Missed Appointments

Our office has a policy on missed appointments. We understand that inadvertently missing appointments can sometimes happen. However, we must consider how these missed appointments impact the ability of other patients to make appointments. Missed appointments often delay or prevent other patients from receiving timely care. To be fair to all of our patients, the following policy is in place:

1<sup>st</sup> Missed Appointment- No Charge as a courtesy (ONE time only)

2<sup>nd</sup> Missed Appointment- \$75 Charge

3<sup>rd</sup> Missed Appointment- \$75 Charge and will be asked to make Same Day Appointments ONLY

4<sup>th</sup> Missed Appointment- Dismissal from our Practice

## Late Policy

We try to be flexible and accommodate patients and their busy schedules to the best of our ability. In order to provide the best service to all of our patients and for staff schedules/patient flow we ask that you, Please arrive on time. If you are more than 15 minutes late for an appointment you may be required to reschedule. When patients arrive late, it delays the next patient's appointment time.



