BigBend Pediatric Care — Family Registration Form

CHILDREN'S INFORMATION - PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT

Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ________
Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ________
Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ________
Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ________

PARENT/GUARDIAN INFORMATION

☐ Father ☐ Mother ☐ Other: ________ Name: ____________ DOB: ________ Email: ____________	Address:	☐ Cell ☐ Home Primary Phone #:
☐ Father ☐ Mother ☐ Other: ________ Name: ____________ DOB: ________ Email: ____________	Address:	☐ Cell ☐ Home Primary Phone #:

EMERGENCY CONTACTS

(LIST ADDITIONAL PERSONS WHO MAY BRING CHILDREN FOR APPOINTMENTS OR WHO WE ARE AUTHORIZED TO COMMUNICATE WITH FOR MEDICAL INFORMATION)

Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home
Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home
PREFERRED PHARMACY NAME:	**ADDRESS:**	**PHONE#**

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE: ID#	Subscriber:	DOB:
INSURANCE: ID#	Subscriber:	DOB:

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

✓ I understand that I am financially responsible for all professional charges that my children may incur.

✓ All co-payments, co-insurances, non-covered charges and deductible owed based on the nature of the visit are due at time of service.

✓ I hereby authorize payment of medical benefits direct to BigBend Pediatric Care. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.

✓ Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to BigBend Pediatric Care to treat my child in their office as required by the events of that emergency situation.

✓ Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for BigBend Pediatric Care, LLC.

______________________________ ______________________________ ____________

Parent/Guardian Signature (Patient Signature if 18 or older) Printed Name Date

BIGBEND PEDIATRIC CARE, LLC
Patient Medical History Form

Date	Child's Name	Nickname	DOB	M F

Previous Physician/Office	Request for Records Transfer Complete Y N	Date of Last Physical

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

Birth History

Birth weight _____ Preg # _____ Mom's age _____
Was the baby born on time?_____ Early?_____ Late? _____
If early, how many weeks gestation? _____
Did mother have any illness or problems with her pregnancy? ☐ Y ☐ N
Explain _____

During pregnancy, did mother:
Smoke ☐ Y ☐ N Drink alcohol ☐ Y ☐ N
Use drugs or medications ☐ Y ☐ N
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?
If Cesarean, why? _____
Did your baby have any problems right after birth? ☐ Y ☐ N
Explain _____

Was initial feeding ☐ Breast Milk? ☐ Formula?
Did your baby go home with mother from the hospital? ☐ Y ☐ N
Explain _____

Current and Past History

Is your child currently on any medication? ☐ Y ☐ N Explain _____
Does your child have any serious or chronic illnesses? ☐ Y ☐ N Explain _____
Has your child had serious injuries or accidents? ☐ Y ☐ N Explain _____
Has your child had any surgery? ☐ Y ☐ N Explain _____
Has your child ever been hospitalized? ☐ Y ☐ N Explain _____
Is your child allergic to any medicine or drugs? ☐ Y ☐ N Explain _____
Has your child had any reactions to immunizations? ☐ Y ☐ N Explain _____

Does Your Child Have, or Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia ☐ Y ☐ N Explain _____
Nasal allergies or eczema ☐ Y ☐ N Explain _____
Frequent ear infections or sore throats ☐ Y ☐ N Explain _____
Problems with ears or hearing ☐ Y ☐ N Explain _____
Problems with eyes, vision, or teeth ☐ Y ☐ N Explain _____
Frequent headaches or other neurologic problems ☐ Y ☐ N Explain _____
Frequent abdominal pain ☐ Y ☐ N Explain _____
Constipation requiring doctor visits ☐ Y ☐ N Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old) ☐ Y ☐ N Explain _____
Any heart problem or heart murmur ☐ Y ☐ N Explain _____
Anemia or bleeding problem ☐ Y ☐ N Explain _____
Thyroid or other endocrine problem ☐ Y ☐ N Explain _____
Diabetes ☐ Y ☐ N Explain _____
ADHD ☐ Y ☐ N Explain _____
Mental health issues (anxiety, depression) ☐ Y ☐ N Explain _____
Use of alcohol or drugs ☐ Y ☐ N Explain _____

Any other medical or mental health issues/problems _____

Does your child see any specialists? ☐ Y ☐ N If yes, Who?_____
For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, Speech Therapy? ☐ Y ☐ N Explain _____

Is your child in special or resource classes in school? ☐ Y ☐ N Explain _____

Do you have any other issues or concerns not listed above? _____

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Child Care: _____

Smokers in household? ☐ Y ☐ N Pets in household? ☐ Y ☐ N

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? _____

_____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had The following:

Alcohol/Drug Abuse	☐ Y ☐ N	Who_____	Comments_____
Allergies	☐ Y ☐ N	Who_____	Comments_____
Anesthesia Risk	☐ Y ☐ N	Who_____	Comments_____
Arthritis	☐ Y ☐ N	Who_____	Comments_____
Blood Disease	☐ Y ☐ N	Who_____	Comments_____
Cancer	☐ Y ☐ N	Who_____	Comments_____
Diabetes	☐ Y ☐ N	Who_____	Comments_____
Genetic	☐ Y ☐ N	Who_____	Comments_____
Gastroenteritis	☐ Y ☐ N	Who_____	Comments_____
Genitourinary	☐ Y ☐ N	Who_____	Comments_____
Heart	☐ Y ☐ N	Who_____	Comments_____
Hypertension	☐ Y ☐ N	Who_____	Comments_____
Lipids	☐ Y ☐ N	Who_____	Comments_____
Neurologic Diagnosis	☐ Y ☐ N	Who_____	Comments_____
Psychiatry	☐ Y ☐ N	Who_____	Comments_____
Ophthalmology	☐ Y ☐ N	Who_____	Comments_____
Respiratory	☐ Y ☐ N	Who_____	Comments_____
Skin	☐ Y ☐ N	Who_____	Comments_____
Stroke	☐ Y ☐ N	Who_____	Comments_____
Thyroid	☐ Y ☐ N	Who_____	Comments_____
Negative Family History	☐ Y ☐ N	Who_____	Comments_____

Additional Family History/Comments _____

_____

_____

Initial Review (initials/date):

BigBend Pediatric Care, LLC
13131 Kings Lake Drive, Suite 101,
Gibsonton, FL 33534

Payment Policy and Procedures

Thank you for choosing BigBend Pediatric Care for your child's medical care. The following is an explanation of our payment procedures and office policies. Please read carefully, print and sign below.

1. Payment is due at the time of service. We do not bill for deductibles or co-pays. We accept cash, Visa, MasterCard, Discover and American express. ***We do not accept personal checks.*** Patients utilizing our cash pay program must pay before each visit.
2. The parent or guardian who brings the child for their visit is responsible for payment at the time of service. We do not intervene between divorced/separated parents or in the matter of custody issues– reimbursement will need to be between parents or guardians.
3. Appointments must be cancelled within 4 hours of the scheduled time in order to avoid a $25.00 No Show Fee. We never make appointments without your consent. We give a courtesy text, email or call 1 day and 4 days prior to your appointment. It is your responsibility to keep your contact information current and to cancel any appointments made. You may opt out of these communications at any time.
4. Account balances must be paid prior to any future visits. If a balance is due, a payment must be collected or payment arrangements made before being seen. Emergent cases will be considered.
5. Account balances that exceed 90 days past due are sent to an outside collection agency. You will be responsible for all collection and legal fees that accrue by the outside agency. Payment must be made before any future appointments.
6. We will gladly bill your primary and or secondary insurance for you. It is your responsibility to keep your **Coordination Of Benefits** current with your insurance providers. Failure to do so may result in lack of payment from your carriers. We are not responsible for non-payment from your insurance plan due to missing COB's and any balances will become subscriber responsibility due in full. ***Failure to disclose a Commercial Insurance as Primary when you have Nevada Medicaid constitutes Medicaid Fraud and Abuse**. Medicaid states we must bill your Primary Insurance first before billing Medicaid.
7. In order to bill your insurance company, we must have an up to date insurance card. If we are unable to verify your insurance coverage at time of service, you will be considered a cash pay patient.
8. Most importantly, BigBend Pediatric Care wants the best care possible for your child and we understand you may have certain financial difficulties. Please feel free to discuss any financial matters with our billing department.

I have read the above policy and agree to abide by the terms of this agreement.

Signature: _____/_____ Date: _____
Parent or Legal Guardian Print Name Signature

Patient Name: _____ DOB: _____

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments Vaccines/shots
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the Treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered Medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this Consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that **Big Bend Pediatric Care/Dr.Garcia** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Big Bend Pediatric Care/Dr.Garcia** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. A photocopy of the consent shall be considered as valid as the original.

I acknowledge that I have been given the **Big Bend Pediatric Care/Dr.Garcia** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the **Patient Consent Form** the statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature **Date**

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to **Big Bend Pediatric Care/Dr.Garcia**. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Big Bend Pediatric Care** to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

Signature_____ **Date**_____

BigBend Pediatric Care, LLC
13131 Kings Lake Drive, Suite 101, Gibsonton, FL 33534
Phone: 813-952 3415
Fax: 813-677 1892

Authorization for Release of Medical Records

PATIENT INFORMATION (Please Print)

Patient's Full Name: _____ **DOB:** _____

Patient's Full Name: _____ **DOB:** _____

Patient's Full Name: _____ **DOB:** _____

Parent/Guardian Name: _____ Phone # _____

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

From:

Physician's Name: _____

Name of Practice: _____

Practice Phone # _____ Practice Fax # _____

To:

BigBend Pediatric Care, LLC
13131 Kings Lake Drive, Suite 101, Gibsonton, FL 33534
Gibsonton, FL 33534
Phone: 813-672 6092
Fax: 813-677 1892

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory and diagnostic test.

By my signature, I authorize the release of all medical records, I understand and accept the terms of the authorization to release my protected health information (PHI)

_____ _____

Signature of Parent/Legal Guardian or Representative Date