

Nadal Pediatrics

813-655-0292
621 Victoria St
Brandon, FL 33510

813-681-7101
376 E. Bloomingdale Ave
Brandon, FL 33511

Patient Information

Date: _____

Patient Name: _____ D.O.B.: _____

Address : _____ Sex: _____

City: _____ Zip: _____ Tel.: () _____

S. S.: _____ Cell: () _____

Patient's Allergies: _____

Referred by: _____ Address: _____

Father's Name: _____

Occupation: _____ Employed By: _____

Telephone: _____ Address: _____

S.S. #: _____ Drivers Lic. #: _____

D.O.B.: _____ Race: _____ Ht.: _____

Mother's Name: _____

Occupation: _____ Employed By: _____

Telephone: _____ Address: _____

S.S. #: _____ Drivers Lic. #: _____

D.O.B.: _____ Race: _____ Ht.: _____

Person responsible for this account: _____

Insurance company name and address: _____

Policy Holder: _____

Policy Number: _____

Name of a relative **not** living with you: _____

Address: _____ Telephone: _____

Relationship: _____ Occupation: _____

*** Important Information Regarding Your Account ***

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services

I am aware that some services performed by Nadal Pediatrics may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

Waiver of "Usual, Customary and Reasonable" Clauses

(For patients with "UCR" coverage) I acknowledge that the fees charged by Nadal Pediatrics for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable", due to specialized services and staff. However, I agree to pay Nadal Pediatrics fees in full, even if the amount is greater than what I am reimbursed by my insurance company.

Bill to/Payment Instructions

Commercial Insurance

Initial

I hereby authorize and request Nadal Pediatrics to bill my insurance company for services provided to my child.

Medicaid

Initial

I request payment of Medicaid benefits to be made to Nadal Pediatrics on my behalf for services rendered to my child

Office Policies

It is our policy that office visits be paid in full at the time of visit

I fully understand that if my account should need to be turned over to a collection agency for non-payment, that I will be charged an additional percentage of the amount to cover the agency's fees.

Signature

Permission for Treatment

Permission is hereby granted for physicians, employees or, agents of Nadal Pediatrics to render the patient named below such medical and surgical treatment as is deemed necessary.

Permission to Release Medical Information

I authorize Nadal Pediatrics to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-payers or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. **This authorization is valid for every visit to Nadal Pediatrics until written notice revoking it is provided.**

I release Nadal Pediatrics of all responsibility for loss of confidentiality through access and/or copies made of records released in compliance to this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payment, release of information, and permission for treatment.

Patients Name _____

Patient or Legal Guardian's Signature _____ Date _____

If legal Guardian, Relationship to Patient _____

Nadal Pediatrics

813-655-0292
621 Victoria St
Brandon, FL 33510

813-681-7101
376 E. Bloomingdale Ave
Brandon, FL 33511

Pediatric Health Questionnaire

Child's Name _____ D.O.B. _____ Date _____

Lives with _____ Daycare/School _____

HISTORY IS TO BE FILLED OUT BY A PARENT/GAURDIAN

Pregnancy and Birth

1. Did the mother have any illness or problems during pregnancy? No ____ Yes ____
2. Did the baby come on time? Yes ____ No ____
3. What was the birth weight? _____
4. Did the baby have any problems just after birth? No ____ Yes ____
5. Did the baby have any trouble while in the hospital? No ____ Yes ____

Feeding and Digestion

1. Was there severe colic or any unusual feeding problems the first 3 months? No ____ Yes ____
2. Is your child's appetite usually good? Yes ____ No ____
3. Is it good now? Yes ____ No ____
4. Do any foods disagree with him/her? No ____ Yes ____
5. Does he/she often have diarrhea? No ____ Yes ____
6. Is constipation a problem? No ____ Yes ____
7. Does he/she take vitamins? Yes ____ No ____
8. If still on formula, which one do you use? _____

Family History

1. Are the child's parents both in good health? Yes ____ No ____
2. Does either parent smoke? No ____ Yes ____
3. List the ages, sex and general health of the brothers and sisters:

4. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers or sisters have had:
Tuberculosis, Diabetes, Asthma, Allergy, Seizures, Cancer, Mental Illness, inherited diseases, Hypertension, Heart Disease, Alcoholism
5. Have any of your children died? No ____ Yes ____

Medical History Development

1. Has your child had more than 4 bouts of ear infection in 1 year? No ____ Yes ____
2. Does he/she have more than 3-4 colds or sore throats with fever in a year? No ____ Yes ____
3. Does he/she have any trouble with urination? No ____ Yes ____
4. Has he/she ever had a convulsion? No ____ Yes ____
5. Does he/she hear well? Yes ____ No ____

- 6. Has he/she had any trouble with eyes? No ____ Yes ____
 - 7. At what age did he/she sit alone? _____
 - 8. At what age did he/she walk alone? _____
 - 9. Did your child say any words by the time he/she was 18 months old? Yes ____ No ____
 - 10. Does he/she have any trouble sleeping now? No ____ Yes ____
 - 11. Are there any concerns with his/her teeth? No ____ Yes ____
 - 12. Has your child had any serious accidents or broken bones? No ____ Yes ____
 - 13. Does he/she take daily medications? _____
 - 14. Other disease or serious illnesses? _____
 - 15. Any hospitalizations? For what? _____
-
16. Any operations? _____

Allergies

- 1. Has your child ever had eczema or hives? No ____ Yes ____
 - 2. Has your child ever had wheezing or asthma? No ____ Yes ____
 - 3. Has he/ she had any allergies or reactions to any medicines or injections? No ____ Yes ____
- List: _____

Psycho-Social History

- 1. Is your child doing well in school? Yes ____ No ____
- 2. Does he/she get along well with other children? Yes ____ No ____
- 3. Does your child have any behavior problems that concern you? No ____ Yes ____
- 4. Daycare or sitter? No ____ Yes ____

Immunizations

- 1. How many "DPT; or diphtheria, tetanus and whooping cough shots has your child had? _____ Date _____
- 2. How many doses of polio vaccine? _____ Date _____
- 3. Has your child had the Measles/Mumps/Rubella Vaccine? Yes ____ No ____
- 4. Has he/she had a skin test for TB? Yes ____ No ____
- 5. Any other vaccines? List: _____

Parent/Guardian Signature _____ Relationship _____ Date _____

Any checks in the right hand column are investigated

Reviewed by _____

Nadal Pediatrics

813-655-0292
621 Victoria St
Brandon, FL 33510

813-681-7101
376 E. Bloomingdale Ave
Brandon, FL 33511

Authorization for Medical Treatment/Immunizations

Date _____

I, _____ authorize the following people to bring
Parent/Guardian's Name
_____ into Nadal Pediatrics for medical treatment and/or

Patient's Name

Immunizations:

Please Print Name

Relationship to Patient

Please Print Name

Relationship to Patient

Please Print Name

Relationship to Patient

Please Print Name

Relationship to Patient

This authorization is valid until written notice revoking it is provided.

Parent/Guardian Signature

Date