Children's Health Center Inc.

NEW PATIENT REGISTRATION *(PLEASE PRINT)*

PATIENT INFORMATION

PATIENT NAME: FIRST	INITIAL	LAST	RESPONSIBLE FOR PAYMENT? ☐ YES ☐ NO
PATIENT ADDRESS: NUMBER & STREET		APT #	
CITY:	STATE:	ZIP CODE:	HOME PHONE NO.: ( )
Date of Birth: ________ SEX: MALE ☐ FEMALE ☐	MARITAL STATUS: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ________		SOCIAL SECURITY #:
EMPLOYER NAME:	EMPLOYER ADDRESS:		EMPLOYER PHONE NO.: ( )
SECOND HOME ADDRESS:		DATES THERE:	HOME PHONE NO.: ( )

IF PATIENT IS A DEPENDENT, GIVE GUARDIAN/PARENT INFORMATION

MOTHER'S NAME: FIRST	INITIAL	LAST	RESPONSIBLE FOR PAYMENT? ☐ YES ☐ NO
ADDRESS:	CITY	STATE	ZIP CODE
HOME PHONE NO: ( )	EMPLOYER:	WORK PHONE NO.: ( )	EXT.
FATHER'S NAME: FIRST	INITIAL	LAST	RESPONSIBLE FOR PAYMENT? ☐ YES ☐ NO
ADDRESS:	CITY	STATE	ZIP CODE
HOME PHONE NO: ( )	EMPLOYER:	WORK PHONE NO: ( )	EXT
GUARDIAN'S NAME: FIRST	INITIAL	LAST	RESPONSIBLE FOR PAYMENT? ☐ YES ☐ NO
ADDRESS:	CITY	STATE	ZIP CODE
HOME PHONE NO: ( )	EMPLOYER:	WORK PHONE NO: ( )	

INSURANCE INFORMATION

PRIMARY INSURANCE:	GROUP #:	POLICY #:
ADDRESS:		PHONE NO: ( )
POLICY HOLDER'S NAME:	SOCIAL SECURITY #:	
DOB:	SEX:	RELATIONSHIP TO PATIENT:
SECONDARY INSURANCE:	GROUP #:	POLICY #:
ADDRESS:		PHONE NO: ( )
POLICYHOLDER'S NAME:	SOCIAL SECURITY #:	
DOB:	SEX:	RELATIONSHIP TO PATIENT:

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: FIRST	INITIAL	LAST	RELATIONSHIP TO PATIENT:
HOME PHONE NO.: ( )	WORK PHONE NO: ( )		

OTHER FAMILY PHYSICIAN OR PEDIATRICIAN

PHYSICIAN NAME:			PHONE NO.: ( )
ADDRESS:	CITY	STATE	ZIP CODE

REFERRING PHYSICIAN

PHYSICIAN'S NAME:			PHONE NO.: ( )
ADDRESS:	CITY	STATE	ZIP CODE

REFERRED BY: (Check One) ☐ NEW - Newspaper ☐ YEL - Yellow Pages ☐ SEL - Self ☐ FAM - Family/Friend ☐ MLR - Mailer ☐ AAN - Ask-A-Nurse ☐ OTH - Other

CHILD HEALTH HISTORY

PATIENT NAME:	☐M ☐F	DOB

ALLERGIES

DRUG:
FOOD:
OTHER:

CURRENT MEDICATIONS

PRESCRIPTION:
OVER THE COUNTER:

PRENATAL & DELIVERY HISTORY

MOTHER'S AGE AT PREGNANCY: _____
ILLNESS DURING PREGNANCY:
MEDS DURING PREGNANCY:
BIRTH WEIGHT _________ APGAR _________
TYPE OF DELIVERY:
WHERE DELIVERED:
COMPLICATIONS :

FAMILY HISTORY ✔ Check if present / Check none if not applicable

☐A.I.D.S.	☐BIRTH DEFECTS	☐MUSCULAR DYSTROPHY
☐DIABETES	☐HEART DISEASE	☐MENTAL ILLNESS
☐CANCER	☐HIGH BLOOD PRESSURE	☐SUDDEN INFANT DEATH
☐CONVULSIONS	☐HIGH LIPIDS (CHOL/TRIG)	☐THYROID DISEASE
☐ALLERGIES	☐KIDNEY DISEASE	☐TUBERCULOSIS
☐ASTHMA	☐ANEMIA/BLOODDISORDER	☐ALCOHOL/DRUG ABUSE
☐MIGRAINE	☐PSYCHIATRIC	☐NONE

GROWTH & DEVELOPMENT

PHYSICAL	AGE	SOCIAL	AGE	COMMUNICATION	AGE
Holds head up		Smiles		Coos	
Rolls over		Reaches for Objects		Laughs	
Sits alone		Drinks from cup		Laughs	
Walks		Scribbles		Babbles	
Jumps in place		Feeds self		First words	
Catches a ball		Toilet trained		Uses sentences	
Jumps rope		Draws triangle		Reads words	
Rides a bicycle		Dresses self		Tells story	

SOCIAL BEHAVIOR

PRIMARY LANGUAGE:
Translation / Hearing Impaired Needs:
Grade in School: Performance in School:
Circle activity: day care preschool after school program sport
AGES 8 YEARS & UP:
Do you smoke? Yes No If yes, # of yrs _____
Drink alcohol? Yes No Amount/day _____ / week _____
Take street drugs or smoke marijuana? Yes No
Sexually active? Yes No Using contraceptives? ☐Yes ☐No

PAST HISTORY ✔ Check if present / Check none if not applicable

☐Recurrent Ear Infections	☐Lead Poisoning
☐Frequent Colds/Sore Throats	☐Sickle Cell Anemia/Blood Disorder
☐Asthma/Bronchitis	☐Seizures
☐Tonsillitis	☐Stomach Problems
☐Allergies	☐Heart Murmur
☐Urinary Tract Infections	☐Diabetes
☐Chicken Pox	☐Bed Wetting
☐Injuries:	☐Surgeries:
☐Blood Transfusion(s)	☐Hospitalized:
LAST TB SCREENING: ☐Pos (+)☐Neg (-) Age Performed:	
IMMUNIZATIONS UP-TO-DATE: ☐ Y ☐ N	
IMMUNIZATION RECORD AVAILABLE ☐ Y ☐ N (If no, bring record)	

TUBERCULOSIS SCREENING

YES	NO	
		• Do you or any member of your family or close contact have tuberculosis?
		• Contact with persons in jail/prison in past 5 years.
		• Have you or any member of your family or close contact traveled outside the country?
		• Frequently (Every 2-3 years) exposed to the following:
		– HIV+ persons
		– Homeless persons
		-- Residents of nursing homes
		– Institutionalized persons
		-- IV/street drug users

Completed by: ______________________________

Nurse/Doctor Signature: ______________________________ Date: ______________________________

Children's Health Center Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – such as ordering diagnostic tests,
- Payment – such as submitting billing information to your insurance company, and
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.

In addition to the above, your medical information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and are unable to do so; we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances; or we created or received the information in treating an inmate.

You have a right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree to any requested restriction.
- Receive confidential communications from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice.
- Abiding by the terms of this notice.
- Providing written notice of any change to this notice.

Complaints:

You may complain to us or to the Health & Human Services secretary if you believe that your privacy has been violated. If you wish to file a complaint with us, please provide the office manager with written notice of how you believe we violated your privacy. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks, and we will not retaliate for any allegations you make.

Authorizations:

Upon your authorization, we may disclose your medical information to a requesting entity, such as an attorney, another provider, or a relative. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

Patient contact:

We may contact you to provide appointment reminders, treatment information, or for patient satisfaction surveys.

To obtain information, contact our office manager at 813-677-2222 (Tampa) or 813-677-2222 (Riverview).

Parent / Guardian Signature ______________________________ Date ______________

Chilaren's Health Center Inc.

*** 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 Children's Health Center may be considered "non-covered" by my insurance carrier or Medicare, 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 Children's Health Center 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 Children's Health Center fees in full, even if the amount is greater than what I am reimbursed for from my insurance company.

BILL TO/PAYMENT INSTRUCTIONS

☐ **COMMERCIAL INSURANCE**

Initial I hereby authorize and request Children's Health Center to bill my insurance company for services provided to me.

☐ **MEDICAID**

Initial I request payment of Medicaid benefits to be made to Children's Health Center on my behalf for services rendered to me.

☐ **MEDIGAP** ______________________ ______________ ______________________

Name of Beneficiary Medigap Policy Number Health Insurance Claim Number

Initial I request payment of Medigap benefits to be made to Children's Health Center on my behalf for services rendered to me.

PERMISSION FOR TREATMENT

Permission is hereby granted for physicians, employees or agents of Children's Health Center to render the patient named below such medical and surgical treatment as is deemed necessary.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize Children's Health Center 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-party payors 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 Children's Health Center or its affiliates until written notice revoking it is provided.**

I release Children's Health Center 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.

Patient's Name ____

Patient or Legal Guardian's Signature ______________________________ Date ______________

If Legal Guardian, Relationship to Patient ______________________________

CHILDREN'S HEALTH CENTER, INC.

Elizabeth Yakubu, M.D.   Alrick Drummond, M.D.

MEDICAL TREATMENT AUTHORIZATION FORM

Date: ____________________

I hereby give my consent to Children's Health Center to administer treatment to my child ____________________________, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance, if the situation warrants.

________________________________   ________________________________

PARENT'S SIGNATURE   WITNESSED BY

I hereby authorize the following person(s) to authorize medical treatment for my child named above, in my absence, including examination, performance of appropriate laboratory tests and x-rays, and the administration of any necessary medications, including immunizations.

Authorized Agent's Name:	Relationship:	Phone#:
1. ______________________	________________________	__________________
2. ______________________	________________________	__________________
3. ______________________	________________________	__________________
4. ______________________	________________________	__________________

CHILDREN'S HEALTH CENTER INC

Authorization for Use/Disclosure of Protected Health Information

PATIENT NAME______________________ DOB______________

PERSON(S)/ORGANIZATION TO PROVIDE INFORMATION:

Name: ______________________

Address: ______________________

Phone/Fax: ______________________

PERSON(S)/ORGANIZATION TO RECEIVE INFORMATION:

CHILDREN'S HEALTH CENTER, INC.

☐ 13043 Summerfield Square Dr.
Riverview, FL 33578
813-677-2222
813-677-2241 Fax

☐ 11464 N 53rd St.
Tampa, FL 33617
813-914-7772
813-914-0014 Fax

INFORMATION TO BE RELEASED:

(Check ALL that apply) Date(s)

- ☐ History & Physical Exam ____________
- ☐ Office Visits ____________
- ☐ Lab Reports ____________
- ☐ X-Ray Reports ____________
- ☐ Patient Medical Photos ____________
- ☐ Shot Records
- ☐ Growth Charts

Other ____________ ____________

I specifically authorize the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug use)
- ☐ Mental Health (including psychotherapy notes)
- ☐ HIV related information (including AIDS related testing
- ☐ Generic Testing

X______________________

Signature

PURPOSE OF DISCLOSURE:
☐Changing Physicians ☐ Consult/Second Opinion ☐ Consulting Care
☐ Legal ☐ Other ______________________

The authorization will expire on ______________ (NOTE: If left blank, it will expire 12 months from date signed).

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. Refuse to sign this authorization and that my refusal will not affect to obtain treatment, payment or my eligibility for benefits; however, the office has the right to deny the above request.
4. Inspect or obtain a copy of my information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the organization that receives the information is not health care provide, plan or business associates (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by Federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

______________________ __________ OR ______________________ __________

Signature of Patient DATE Parent/Legal Guardian/Authorized Person DATE

OFFICIAL USE ONLY:

INFORMATION RELEASED BY: ______________ DATE RELEASED: ______________

CHILDREN'S HEALTH CENTER, INC.
Pharmacy Listing

❑ 13043 Summerfield Square Dr.
Riverview, FL 33578
813-677-2222
813-677-2241 Fax

❑ 11464 N 53rd St.
Tampa, FL 33617
813-914-7772
813-914-0014 Fax

NAME:_________________________ DATE OF BIRTH:__________ EMAIL:__________

LOCALPHARMACY:_________________________

ADDRESS:_________________________

____

____

TELEPHONE:_________________________

FAX:_________________________

Medication List - Please list currently prescribed medications and any supplements.

Medication Name	Dosage	How often?	30/90 day RX?	Refills needed?

Allergies - Please describe any allergic reactions to medications, foods, or the environment.

____

____

____

DOMESTIC VIOLENCE SCREEN

PLEASE CIRCLE YES OR NO

IF ANSWER IS YES PLEASE

DESCRIBE:

---

1. Is anyone in the family afraid of or intimidated by other family members? YES NO

   DESCRIBE:

2. Anyone else in the family has been hurt by other family members? YES NO

   DESCRIBE:

3. Anyone else in the family has been threatened to hurt with or without weapon? YES NO

   DESCRIBE:

4. Is there anything going on in your home that makes you sad, scared or worried about your mom? YES NO

   DESCRIBE:

5. Is there anything going on in your home that makes you sad, scared, or worried about yourself? YES NO

   DESCRIBE:

REFERRAL _____YES_____NO

____FAMILY JUSTICE CENTER OF HILLSBOROUGH COUNTY (813)490-9428

NAME____________________

____THE SPRING OF TAMPA BAY (813)247-5433 EXT 318

D.O.B ____________________

____2-1-1 TAMPA BAY (813)959-4914

DATE ____________________

____CHILD ABUSE HOTLINE (800)962-2873

Please bring to the exam room to review with the doctor.

Step 1: For the Parent/Patient to fill out

Have you smoked a cigarette, even a puff, in the last 30 days?

❒ Yes ❒ No

Would you like to receive FREE resources from the Tobacco Quitline?

❒ Yes ❒ No ❒ Not Sure

Would you like nicotine patch and gum to help you cut down or quit smoking?

❒ Yes ❒ No ❒ Not Sure

Step 2: For office use (EMR Entry)

Document Tobacco Use/Exposure

- ❒ Tobacco Users: ❒ Mother ❒ Father ❒ Patient ❒ Other
- ❒ Smoke-free Home Rule: ❒ Yes ❒ No
- ❒ Smoke-free Car Rule: ❒ Yes ❒ No ❒ No Car

Document Services provided

- ❒ Prescription given for patch or gum
- ❒ Enrolled in the Quitline
- ❒ Enrolled in Smoke-free TXT
- ❒ Set a date to quit for ____________________

Code 989.84 to document parental tobacco use/assistance (Toxic effect of tobacco)

Code 305.1 to document teen tobacco use/assistance (Tobacco use or dependence)

— — — TEAR HERE — — — TEAR HERE — — — TEAR HERE — — — TEAR HERE — — — TEAR HERE — — —

Call 1-800-784-8669 for free help quitting
OR
Text the word "QUIT" (7848) to QUIT (47848) for free help.

____

____

____

Name ____________________ Date __________

Address ____________________ DOB __________

Nicotine Patch (check strength)

❒ 21 mg ❒ 14 mg ❒ 7 mg

Apply 1 patch for 16-24 hours each day

Dispense 2 months supply

Refill NR 1 2 3 4 5

Prescription is void if more than one (1) prescription is written per blank.

Text the word "QUIT" (7848) to QUIT (47848) for free help
OR
Call 1-800-784-8669 for free help quitting.

____

____

____

Name ____________________ Date __________

Address ____________________ DOB __________

Nicotine Gum

❒ 4 mg

Chew 1 piece every 1-2 hours

Dispense 2 months supply

Refill NR 1 2 3 4 5

Prescription is void if more than one (1) prescription is written per blank.