BENNETT PEDIATRICS, LLC
Phone: 352.404.7728
Fax: 352.404.7724
365 Citrus Tower Blvd Ste 104
Clermont, FL 34711-6532
www.BennettPediatrics.com

Bennett PEDIATRICS
CARING FOR THE CHILD. CARING FOR THE FAMILY.

PATIENT INFORMATION

PATIENT'S NAME: _____ AGE: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: (_____) _____ M/F: _____ SOCIAL SECURITY #: _____
MOTHER'S NAME: _____ SS #: _____ CELL PH.: (_____) _____
ADDRESS AND PHONE (if different): _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (_____) _____ EXT. _____
FATHER'S NAME: _____ SS #: _____ CELL PH.: (_____) _____
ADDRESS AND PHONE (if different): _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (_____) _____ EXT. _____
REFERRED BY: _____ PHONE: (_____) _____

IN CASE OF EMERGENCY
CLOSEST RELATIVE NOT LIVING WITH YOU: _____ PHONE: (_____) _____

RESPONSIBLE FOR BILL

LEGAL NAME: _____ RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
DRIVER LICENSE #: _____ STATE ISSUED: _____
ADDRESS: _____
MAILING ADDRESS (if different): _____
PHONE: HOME (_____) _____ WORK (_____) _____ CELL (_____) _____
E-MAIL ADDRESS: _____ EMPLOYER: _____

INSURANCE COMPANY INFORMATION

INSURANCE: _____ GROUP NAME OR #: _____
ADDRESS: _____ PHONE: (_____) _____
POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

INSURANCE: _____ GROUP NAME OR #: _____
ADDRESS: _____ PHONE: (_____) _____
POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

PLEASE ANSWER THE FOLLOWING

Have you or anyone in your immediate family been a patient in our office before? □ Yes □ No
If Yes, please list:
Name: _____ Relationship: _____ When: _____
Name: _____ Relationship: _____ When: _____
Name: _____ Relationship: _____ When: _____

Has your child been seen in the hospital by our physician? □ Yes □ No

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NEWBORN HISTORY FORM

Mother's Name: _____ Mother's Phone: _____

Mother's Address: _____

Father's Name: _____ Father's Phone: _____

Father's Address: _____

Infant's Name: _____

PRENATAL HISTORY

1. Mother's age during pregnancy _____
2. Number of prenatal visits _____
3. Group B Strep Positive □ Yes □ No
4. Any of the following positive during pregnancy:

□ Syphilis □ Gonorrhea □ Herpes
□ Chlamydia □ HIV □ Hepatitis B

5. Any medication during this pregnancy? _____

_____

6. Any illness during this pregnancy? _____

_____

BIRTH HISTORY

1. How many weeks at birth? _____
2. Hospital of birth? _____
3. Normal Delivery or C-section? _____
4. Birth Weight? _____
5. Birth Length? _____
6. How many days in hospital? _____
7. Any problems at birth? _____
8. Did infant get jaundiced? _____
9. If jaundiced, was phototherapy done? _____
10. Did infant get antibiotics? _____
11. Hepatitis B vaccine received? _____
12. Hearing screen passed? _____
13. If male, was he circumcised? _____

FEEDING HISTORY

1. Breast or formula feeding? _____
2. If formula feeding, which formula? _____
3. If breast feeding, latching well? _____
4. Excessive spit ups? _____
5. Any unusual colic? _____

FAMILY HISTORY

1. Both parents in good health? _____
2. Check any of the following that this infant's parents, grandparents, aunts, uncles, brothers or sisters have/ had:

□ Diabetes □ Hypertension □ Asthma
□ Allergies □ Seizures □ Cancer
□ AIDS □ Deafness □ Kidney Disease
□ Alcoholism □ Tuberculosis □ SIDS
□ Heart Disease □ Inherited Diseases

3. Have any of your children died? _____

SOCIAL HISTORY

1. List ages and gender of household members:

_____

_____

_____

_____

2. Does the baby sleep in a bassinet? _____
3. Does either parent smoke? _____
4. Any pets? _____
5. Any recent changes in the family? (death, move, separation, domestic violence, etc) _____

_____

5. What religion do you practice? _____

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VACCINE ADMINISTRATION CONSENT

Name of Patient: _____

Date of Birth: _____

The doctor will keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine lot number and the signature and title of the person who gave the vaccine.

"I have been provided with a copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Sheet(s) and have read or have had the information explained to me about the diseases and the vaccines listed below. I have had a chance to ask questions that answered to my satisfaction. I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request)."

One or more of the following vaccines may be given at the age appropriate time:

- Prevnar
- Tetanus, diphtheria and acellular Pertussis (TdaP)
- Diphtheria, Tetanus, acellular Pertussis and Inactivated Polio Vaccine (Pediarix)
- Diphtheria, Tetanus, acellular Pertussis (DTaP)
- Diphtheria, Tetanus, acellular Pertussis and HiB titer (Pentacel)
- Haemophilus Influenzae B titer (HiB)
- Measles, Mumps, Rubella (MMR)
- Measles, Mumps, Rubella and Varicella Vaccine (MMRV or ProQuad)
- Rotavirus oral vaccine
- Hepatitis B Vaccine
- Inactivated Polio Vaccine (IPV)
- Varicella Vaccine (Varivax)
- Meningococcal Vaccine (Menactra or Menveo)
- Human Papilloma Virus Vaccine (Gardasil)

Signature of Person to receive the vaccine or person authorized to make this request (Parent or Guardian)

_____ Date: _____

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FINANCIAL POLICY

Thank you for choosing us as your child's health care provider. We are committed to providing your child comprehensive Pediatric care. Please understand that payment of your child's bill is considered part of their treatment. The following is a statement of our financial policy. We require you to read and sign prior to any treatment. **ALL PARENTS MUST COMPLETE ALL PAPERWORK BEFORE THEIR CHILD IS SEEN.**

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR CREDIT CARDS. If a check is returned to us for any reason, your child's account will be charged the amount of the check plus a $25 returned check fee.

USUAL & CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

There is $25 fee for appointments not cancelled within 24 hours prior to your appointment time.

WE CANNOT BILL YOUR INSURANCE COMPANY UNLESS YOU GIVE US A COPY OF YOUR CHILD'S INSURANCE CARD. Without a copy of the card, you will be responsible for 100% of the charges on that date of service. We will file to your insurance company, however, if you must pay a percentage of the bill, it must be paid at the time of service. All co-pays due at the time of service.

For newborns, you will need to contact your insurance company or Human Resources Department within 30 days to be added to your insurance. Otherwise, you will be responsible for the bill.

The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all of the services provided may be no-covered services and not considered reasonable by your insurance policy.

If you are unable to pay the balance in full, we can arrange a payment plan. If the balance is 90 days past due and/or you default on your payment plan, the account will be forwarded to a collection agency. You will be responsible for any fees incurred from the collection agency and/or legal services hired by Bennett Pediatrics, LLC. Furthermore, your child will be discharged from the practice.

In the event that your insurance changes, it is your responsibility to notify us as we may be non-participating providers. Failure to do so will result in you being responsible for all charges incurred. It is not the responsibility of Bennett Pediatrics, LLC to ensure we are providers. Our main concern is the health of our patients.

Regarding HMO, Managed Care and Medicaid plans, you are responsible for making sure that our practice and/or doctors are listed as your child's Primary Care Physician. **Failure to do so will result in you being responsible for all charges incurred.**

We provide lab work as a professional courtesy. You are responsible for providing us with the correct laboratory in which to send lab work. If your child's lab work is sent to an incorrect laboratory, you will be responsible for all charges incurred.

I have read and fully understand Bennett Pediatrics, LLC Financial Policy.

Parent's Name:_____ Child's Name:_____
(PLEASE PRINT) (PLEASE PRINT)

Patient/Parent Signature:_____ Date: _____/_____/_____

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CONSENT FOR EVALUATION, TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I hereby consent to the use and disclosure of my protected health information by Bennett Pediatrics, LLC for the purpose of diagnosing or providing treatment to me or my child, obtaining payment for health care bills or to conduct health care operations of Bennett Pediatrics, LLC.

I have the right to revoke this consent , in writing, at any time, except to the extent that Bennett Pediatrics, LLC has taken action in reliance on this consent.

"Protected Health Information" means health information including demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to present, past or future physical or mental health condition that identifies me or my child or there is reason to believe that this information may identify me or my child.

Bennett Pediatrics, LLC has an established HIPAA Notice of Patient Privacy Practices which is displayed in this office and online. I can obtain a printed copy of this policy at any time.

Patient Name: _____

Parent/Guardian Signature: _____

Relationship to Patient: _____

Date: _____/_____/_____

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COMMUNICATION USE & DISCLOSURE AUTHORIZATION

Date: _____/_____/_____

Patient: _____ Parent/Guardian: _____
(PRINT NAME) (PRINT NAME)

Date of Birth: _____/_____/_____ Patient #: _____

Address: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

□ Referral Information □ Prescription Refill Information □ Test Results

□ Other _____

You may discuss information regarding my treatment and care with the following family members and/or friends:

_____

_____

_____

_____

You may contact me regarding my or my child's treatment and care at the following numbers:

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____/_____/_____

Staff Member: _____

Staff Signature: _____

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ASSIGNMENT OF BENEFITS FORM

Date: ____/_____/ _____

Patient: _____ Parent/Guardian: _____
(PRINT NAME) (PRINT NAME)

Claim Group: _____ SS #/ID #: _____

I hereby instruct and direct _____ to pay by Electronic Funds Transfer (EFT) made out and mailed to:
(INSURANCE COMPANY)

BENNETT PEDIATRICS, LLC
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OR

If my current policy prohibits payment directly to a doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

BENNETT PEDIATRICS, LLC
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For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize doctor to initiate a complaint to Insurance Commissioner for any reason on my behalf.

Signed: _____ Relationship to Patient: _____

Date: _____/_____/____ Witness: _____

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AUTHORIZATION FOR MEDICAL RECORD RELEASE

SECTION I (Must be completed for ALL Authorizations)

Date _____/ _____/ _____

PATIENT'SNAME:_____AGE:_____DATEOFBIRTH:_____

HOME ADDRESS: _____

Persons/organizations providing the information (Complete with address):

_____

_____

_____

Persons/organizations receiving this information (Complete with address):

_____

_____

_____

Specific description of information (including dates) to be used and/or disclosed about me:

_____

_____

_____

_____

*The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV / AIDS related health information and/or records

_____ * Mental health information and/or records

_____ * Genetic testing information and/or records

_____ * Drug/alcohol diagnosis treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.)

SECTION II (Bennett Pediatrics LLC has requested this authorization at the patients or patient's representatives request or direction)

The patient or the patient's representative **must read and initial** the following statements:

_____ I understand that my health care and the payment for my healthcare will NOT be affected if I DO NOT sign this form.

_____ I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

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AUTHORIZATION FOR MEDICAL RECORD RELEASE

[CONTINUED]

SECTION III (Must be completed for ALL Authorizations)

The patient or the patient's representative must read and initial the following statement:

I understand that this Authorization will expire. (Please choose one.)

_____ No expiration (permitted only for Authorization used to create or maintain research databases or repositories).

_____ On _____/_____/_____

Signature of Patient or Patient's Representative (form must be completed before signing):
_____ Date: _____

Print Name of Patient's Representative: _____
Relationship to the Patient: _____