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

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

 13-1222-000-0H01

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INITIAL PEDIATRIC HISTORY FORM

Mother's Name: ______________________________ Mother's Phone: ______________________________

Mother's Address: ____

Father's Name: ______________________________ Father's Phone: ______________________________

Father's Address: ____

Child's Name: ______________________________

BIRTH HISTORY

Birthplace ______________________________

Was pregnancy normal? □ Yes □ No

Was the delivery normal? □ Yes □ No

Birth Weight ___________ Length ______________

Any nursery problems? □ Yes □ No

GROWTH AND DEVELOPMENT

Ages when first:

Sat ______________ Crawled _________________

Rolled ____________ Walked _________________

Talked ____________ Toilet trained _____________

School History:

School Name ______________________________

Year in school __________ Nursery ______________

Grades averaged? ____________________________

School problems? ____________________________

Attends Special school/classes? ________________

Ever seen by psychologist, speech therapist or special teachers? ______________________________

PAST MEDICAL HISTORY

Any problems with:

□ Sleeping □ Bed wetting □ Nail biting

□ Weight Height □ Nightmares

Diet:

Nursed or bottle fed? _________________________

Any colic problems? __________________________

Used special diets? ___________________________

Contagious Diseases (what age?):

Chicken pox ________________________________

Scarlet fever ________________________________

Any other? _________________________________

Current medications? _________________________

____

HOSPITALIZATIONS

When, where, why? ___________________________

____

SURGERY

When, where, why? ___________________________

____

SERIOUS INJURIES

When, where? ______________________________

____

ALLERGIC REACTIONS

Drugs, immunizations, asthma, hives, eczema, etc?

____

FAMILY HISTORY

Father: Living? ______ Age: ______ Height: _______

Mother: Living? ______ Age: ______ Height: ______

Siblings: __________ How many? _______________

Ages _______________ Healthy?________________

Any Family History of:

□ Diabetes □ Allergies □ Convulsions □ Cancer

□ Heart Disease □ Other: _____________________

GENERAL INFORMATION

Has your child had any unusual problems with the following?

Head ____

Eyes ____

Ears/Nose/Throat ______________________________

Chest/Heart/Lungs _____________________________

Stomach _____________________________________

Kidneys _____________________________________

Bladder _____________________________________

Bones/Muscles/Joints ___________________________

Skin ____

Blood _______________________________________

IMMUNIZATIONS

Are vaccines up to date? □ Yes □ No

Did you bring a record of immunizations of your child?

□ Yes □ No

ANY SPECIAL COMMENTS ABOUT YOUR CHILD

____

____

13-1222-000-0E01

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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
365 Citrus Tower Blvd Ste 104
Clermont, FL 34711-6532

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
365 Citrus Tower Blvd Ste 104
Clermont, FL 34711-6532

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: ____