Luisa Carrasquero, MD, FAAP

NEW PATIENT INFORMATION SHEET

Name: _____

Birth Date: _____ Sex: ____M____F

Address: _____

City/State: _____ ZIP: _____

SS# __ __ __- __ __- __ __ __ __

Home Phone#: (____) _____ Cell Phone#: (____) _____

Contact Preference: __Home Phone __Cell Phone__ Home Address

Email address: _____

Parent's information:

Mother's Name: _____

Birth Date: _____ SS#: __ __ __- __ __- __ __ __ __

Address: _____

Phone #: (____) _____

Father's Name: _____

Birth Date: _____ SS#: __ __ __- __ __- __ __ __ __

Address: _____

Phone #: (____) _____

INSURANCE INFORMATION:

Insurance Company: _____

Insurance ID #: _____Account/Group #: _____

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SUBSCRIBER INFORMATION: (if different than the child)

Subscriber's Name: _____

Birth Date: _____ Sex: ___M___F

Relationship to Patient: _____

Address: _____

Pharmacy name, number, and intersection:

_____

_____

THIRD PARTY CONSENT

I authorize Wekiva Springs Pediatrics to communicate with my insurance company to coordinate treatment, to facilitate quality of treatment, and obtain reimbursement. By not signing consent, I am agreeing to full payment at the time of service. ***Initial:*** _____

**** I understand and agree that, regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify the information provided is true and correct. I will notify Wekiva Springs Pediatrics of any changes in the above information, including insurance coverage, in a timely manner.*** **Initial:** _____

PRIVACY PRACTICE

I acknowledge that I have been provided access to **Wekiva Springs Pediatrics** Notice of Privacy Practices (NPP). ____ (Initials)

I have read and understand all the policies of Wekiva Springs Pediatrics including but not limited to: financial policy/office policy/authorization for consent and Insurance responsibility

I acknowledge that I can obtain a copy of the full NPP from the front office and/or **Wekiva Springs Pediatrics website** (Wekivaspringspediatrics.com). If I have any questions regarding the NPP, I will ask to speak with the office manager. ***Initial:*** _____

Parents Print Name: _____

Parent Signature _____**Date:** _____

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Patient Family History

Does any immediate family suffer from any of the following medical conditions? (Father, mother, siblings, grandparents)

Asthma _____

Diabetes_____

Heart Disease_____

Epilepsy_____

Mental Illness_____

High Cholesterol _____

Allergies_____

Other (please specify) _____

Patient Social History (please check all that apply)

Who lives at home? _____

Does anybody smoke in the house? _____

Do you have any pets? _____

Do you have any guns at home? _____

Do you have a pool at home? _____

If yes, does the pool have a fence? _____

Are there any problems with mold/mildew at home? _____

Please list any siblings below

Name: _____ DOB_____

Name: _____ DOB_____

***Do you prefer a specific Dr. for your child's Well visits? _____

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AUTHORIZATION TO TREAT MINOR

(I)(We), the undersigned, parent(s) of _____, a minor, do hereby

Authorize **Wekiva Springs Pediatrics** as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician who works there, whether such diagnosis or treatment is rendered at the office of said physician.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such medical or surgical diagnosis or treatment which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

This authorization is effective _____, 20__, and shall remain effective indefinitely unless sooner revoked in writing delivered to said agent(s)

Date: _____

Parent (Print) _____

Parent (Sign) _____

Legal Guardian _____

Witness (Office) _____ Date _____

Luisa Carrasquero, MD, FAAP
Phone: 407-790-7998 Fax: 877-830-8517

Authorization (autorización)- for records release/request (alta médica)of confidential information

□ **This is to request and authorize you to release to Wekiva Springs Pediatrics**

□ **I hereby authorize Wekiva Springs Pediatrics to release to:**

_____

Physician (médico previo)

_____

Address

_____

Phone **Fax**

I understand and direct that this authorization remain effective for 365 days or until I revoke it in writing. I hereby release **Wekiva Springs Pediatrics** its employees from any and all liability that may arise from the release of this information as I have directed.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.

** PLEASE RELEASE MY MEDICAL RECORDS***

Initial by the item you want to have release

State period of time: From _____to _____.

___1.All Medical records (includes#2-#9)
___ 2. Immunization Records
___3.Consultation
___4. Surgical reports
___5. Laboratory results
___6. X-ray Report
___7. ER records
___8. Newborn/birth records
____9. **Medically Sensitive**: HIV, Mental Health, Substance abuse, STD, Pregnancy if under 18 yrs

_____ ____ _____

Patient Name/Date of Birth Date of authorization

_____ _____

Parent signature /relationship Witness (Office)

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ETHNICITY / RACE / LANGUAGE

ETHNICITY:
(Etnicidad)

__Hispanic or Latino
__Caucasian
__African American
__Other: _____

RACE:
(Raza)

__American Indian or Alaska Native
__Hispanic or Latino
__Black American
__White
__Other Race

LANGUAGE
(Idioma)

__English (Ingles) Primary __ Secondary __
__Spanish (Español) Primary __ Secondary __

Other language:

_____

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PLEASE READ AND SIGN

WEKIVA SPRINGS PEDIATRICS VACCINE POLICY

Wekiva Springs Pediatrics is a private organization; we strongly believe in the importance of vaccinating your child and do not accept families unwilling to vaccinate their children. This is against our philosophy of high quality preventive medicine. We fully support the current immunization schedule, however we will be willing to work a special schedule and discuss immunization concerns with our parents. If you do not agree with our vaccination policy we will be glad to see your child for sick visits and emergencies until you can find another pediatrician within a reasonable amount of time of 30 days from the moment of your first visit.

I have read and accepted Wekiva Springs Pediatrics policy about vaccinations.

Parent Signature _____

Patient Name _____

Witness _____

Date_____/_____/_____

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Financial and Insurance Policies

Please initial below indicating that you have read and understood, and agreed to all the policies contained on this page.

____ I hereby authorize direct payment of medical benefits to Wekiva springs pediatrics for services rendered by the physicians or organization. I understand it is my responsibility to provide correct insurance information and assure Wekiva springs pediatrics and/or its providers are listed as my primary care physicians, if applicable. I also understand that I am responsible for any balances NOT covered by my insurance.

____ Payment for all copays, deductibles, non-covered and self-pay services as well as any balance due is expected at the time of service and must be paid in full upon check in. If payment cannot be made, the appointment will be rescheduled. If you need to make payment arrangements, you must contact the office at least 4 hours prior to the appointment. We accept cash, credit or debit cards. Checks are accepted if you receive a statement and mail in a payment. Thera is a $35.00 return check fee for all checks returned for non-sufficient funds.

____ Blue (shot) and Yellow (physical) forms are provided upon request during the annual wellness exam. Please ask for the forms at the time of the visit. If you do not request these forms at the time of service but need copies at a later date, a $5.00 fee per form will be charged.

____A $15.00 fee will be charged for all sports physical or camp forms.

____If you are unable to keep your appointment, you must contact the office at least 1 hour prior to the appointment to reschedule or cancel. Failure to do so will result in a $15.00 no show fee.

____Patients who reach 3 no show appointments will be discharged from the practice.

____You are responsible for requesting any necessary referrals prior to seeing a specialist and prior to having any tests or procedures performed. When possible, these requests should be made 2 days prior to the specialist appointment date. It is up to the discretion of the Wekiva Springs Pediatrics provider whether or not to issue a referral requested at the time of the visit or procedure.

____ Referrals are NOT a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered test tests and procedure or visits to third party providers are to be directed to your insurance carrier.

____I hereby authorize Wekiva Springs Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

____I certify that the information given by me in the applying for payment under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or the intermediaries of carries' any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of parent/Legal Guardian Date

_____ _____

Print name of Parent/Legal Guardian Print name of patient