Kendall Pediatric Partners

PATIENT INFORMATION:

Name: _____ Date of Birth: _____
Last First

M ( ) F ( ) Child lives with: Father_____ Mother _____ Both _____ Other _____

Address: _____ZIP_____

Primary Phone _____ Alternate Phone _____

Email : _____

Pharmacy and phone #: _____

Parents' Marital Status: Married _____ Separated _____ Divorced _____

Languages spoken at home: English_____ Spanish____ Other_____

Siblings in the office: _____

INSURANCE POLICY HOLDER INFORMATION:(PERSON)

Name: _____ Date of Birth:_____

Address (If different from above)_____

Phone Number _____SS#: XXX-XX-_____ Employer: _____

Email address: _____

OTHER PARENT INFORMATION:

Name: _____

Address: (if different from above) _____

Phone Number _____

Your appointment time has been set aside for you alone; no other patients are scheduled at the same time. If you can't keep it, kindly cancel in advance. There will be a $ 30 charge for missed appointments.

I authorize kendall pediatrics to email specialist referral information. Yes_____ No____

Initials: _____

I hereby authorize payment, directly to Kendall Pediatric Partners, LLC, of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work and vaccines not covered by my insurance contract as performed in the office, and for any co-payments and/or deductible amounts as specified in my insurance contract. I acknowledge that Private Health Information material (HIPAA) is posted, and available upon request

_____ _____ _____

Parent Name Signature Date

Notice of Privacy Practice Acknowledgement

Kendall Pediatric Partners, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

KENDALL PEDIATRIC PARTNERS
Alina Siblesz Ruiz, MD Raquel Olavarrieta, MD

Phone: 305- 274-2255
Fax: 305-274-2211

11400 N. Kendall Dr., A-211
Miami, FL 33176

MEDICAL RECORDS RELEASE REQUEST

Doctor: _____

Phone: _____

Fax: _____

Please release to Kendall Pediatric Partners, all medical records in your possession on:

Patient Name: _____

DOB: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____

Witness Signature: _____

Mail Records **Fax Records** **Patient Pick Up**

Date: _____

Thank you for your kind attention to this matter

CHILD HEALTH HISTORY

Allergies: **Home Phone#:** **Cell Phone #:**

DATE:	NAME PARENT/GUARDIAN:	SIBLINGS:	CARETAKERS:

MEDICAL HISTORY	Answer for each column					
? = Unknown	PATIENT			FAMILY		
Stroke/Hypertension	Yes	No	?	Yes	No	?
Heart Dz / Rheumatic Fever	Yes	No	?	Yes	No	?
Diabetes	Yes	No	?	Yes	No	?
Cancer	Yes	No	?	Yes	No	?
Congenital / Genetic Disorders	Yes	No	?	Yes	No	?
Blood Disorders / Sickle Cell / Rh	Yes	No	?	Yes	No	?
Lung / Tuberculosis / Asthma	Yes	No	?	Yes	No	?
Headaches / Seizures	Yes	No	?	Yes	No	?
Neuro / Mental / Emotional Heath	Yes	No	?	Yes	No	?
Breast Disease	Yes	No	?	Yes	No	?
Gall Bladder / Liver	Yes	No	?	Yes	No	?
Kidney / UTI	Yes	No	?	Yes	No	?
GI Disease	Yes	No	?	Yes	No	?
Substance Abuse	Yes	No	?	Yes	No	?
HIV	Yes	No	?	Yes	No	?
Skin / Skeletal	Yes	No	?	Yes	No	?
Thyroid / Endocrine	Yes	No	?	Yes	No	?

FOR PATIENT ONLY	Patient	Date
Blood Transfusion	Y / N / ?	
Blood Type:	A / B / AB / O Rh + / -	
Rubella	Y / N / ?	
Measles	Y / N / ?	
Mumps	Y / N / ?	
Hepatitis B	Y / N / ?	
STD (specify)	Y / N / ?	
Past vaccine Rxn	Y / N / ?	
Chickenpox	Y / N / ?	
Other		

Delivery History(as applicable)

Mother's Prenatal History

❑SVD

❑C/S Reason: _____

Diabetes ❑yes ❑no controlled: ❑diet ❑insulin

Hypertension ❑yes ❑no

HIV Tested ❑yes ❑no results: ❑pos(+) ❑neg(-)

PPD Tested ❑yes ❑no results: ❑pos(+) ❑neg(-)

ETOH / Tobacco / Drugs ❑yes ❑no

STD _____

RPR ❑pos (+) ❑neg (-)

HBsAg ❑pos (+) ❑neg (-)

Weeks Gestation: _____

Birth Weight: _____

APGAR: _____/_____/_____

Length: _____

Head Circ: _____

Where Delivered: _____

Hearing Screen: _____

NEONATAL PROBLEMS & CONDITIONS

❑Birth Defects _____

❑Jaundice _____

❑Feeding _____

❑Respiratory _____

❑Cardiac _____

❑Sepsis work-up results: ❑pos(+) ❑neg(-)

❑Other: _____

SERIOUS ILLNESS, ACCIDENT, HOSPITALIZATION (S):

MEDICATIONS:

FREQUENT EPISODES OF MINOR ILLNESS:

VITAMINS:

CULTURAL / ALTERNATIVE MEDCINES:

SOCIAL HISTORY

Pool: _____ Gun: _____

ETOH / Tobacco / Drugs: _____

Domestic Violence: _____ Pets: _____

Religion: _____ Language: _____

Family dynamics: _____

PHYSICAL HISTORY (as applicable)

Menarche: _____

Puberty: _____

Acne: _____

Sexual Activity: _____

Signature: _____

Patient Name: _____ **DOB:** _____ **F M Language: E S Other**

Childhood Lead Risk Questionnaire

KENDALL PEDIATRIC PARTNERS
11400 N. Kendall Dr., A-211
(305) 274-2255

Child's Name:	Date of Birth:

Please help us assess your child's risk for lead poisoning by answering the following questions:

		YES	NO
1.	Does your child live or regularly visit a house that was built before 1950?	☐	☐
2.	Does your child live in or regularly visit a house built before 1978 that has been remodeled in the past 6 months?	☐	☐
3.	Has your child moved to the United States within the past year?	☐	☐
4.	Does your child have a sibling or playmate with lead poisoning?	☐	☐
5.	Does your child live in or attend day care in any of the following zip codes? 33125 33126 33127 33128 33129 33130 33131 33140 33133 33134 33135 33136 33137 33138 33139 33141 33142 33144 33145 33147 33150 33132	☐	☐
6.	Does your child receive any type of public assistance (i.e., WIC, food stamps, etc.)?	☐	☐
7.	Is your child enrolled in Medicaid, or does your child receive health care in a publicly-funded clinic?	☐	☐
8.	Does your child live with an adult whose job or hobby involves exposure to lead? Auto/battery repair; Painting; Fishing Plumbing; Steel welding; Pottery work Construction; Police/gun work; Soldering Maritime industry; Stained glass work; Other_____	☐	☐
9.	Does your family use pottery or ceramics for cooking, eating, or drinking?	☐	☐

If you answered yes to any of the questions, your child's doctor will help determine if a blood lead level should be checked. If a level is checked and is found to be greater than or equal to 10 micrograms per deciliter, your child's case will be referred to the Miami-Dade County Health Department for case management.

This questionnaire was adapted from a questionnaire developed by Michael Finer, M.D., Pediatric Professional Associates.