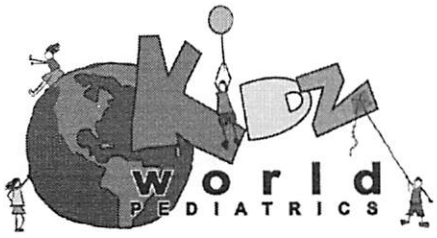

HANS HUBSCH M.D.P.A
500 N Hiatus Rd #103 Pembroke Pines, FL 33026
Office (954) 704-1051 Fax (954) 437-0526

Today's Date: _____

Child's Last Name: _____ First Name: _____Middle Initial: ____

Date of Birth: ____/____/____ Sex: ___Male ___Female Social Security: _____-____-_____

Mother's Last Name:_____First Name:_____Date of Birth:____/____/_____

Father's Last Name:_____First Name:_____Date of Birth:____/____/_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mother's Cell: _____ Father's Cell:_____

EMAIL: _____

EMERGENCY CONTACT

In the event of an emergency, whom shall we contact?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please list anyone who has your permission to bring your child to our office for medical care and treatment in your absence:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

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PRIMARY INSURANCE INFORMATION

Insurance Company: _____Telephone Number:_____

Person Financially Responsible: _____

Employer: _____

Primary Member ID/Policy No: _____Group No: _____

Child's Member ID/Policy No: _____Group No: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____Telephone Number:_____

Person Financially Responsible: _____

Employer: _____

Primary Member ID/Policy No: _____Group No: _____

Child's Member ID/Policy No: _____Group No: _____

RELEASE AND ASSIGMENT

I certify that my child has medical insurance with _____. I understand that I am financially responsible for all charges not paid by my child's health insurance carrier. I hereby authorize the doctors to release all information necessary to secure payment of services and benefits provided to my child.

_____ _____

Signature of Parent/Legal Guardian **Date**

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CLINICAL/HEALTH INFORMATION SHEET

(Please complete this section as detailed as possible. Any area that does not apply, please indicate so by writing N/A)

Child's Name (L/F/M):_____

Birthdate (M/D/YY):_____ Sex: M ____ F____ Race: _____

Father's Name (L/F/M):_____Age:_____

Mother's Name (L/F/M):_____Age:_____

Father's Occupation: _____Mother's Occupation: _____

Number of Siblings: ____Names of Siblings: _____

_____

Family History (Please indicate if any of the following disorders apply)

( ) Seizures ( ) Heart Disease ( ) Asthma ( ) Cancer

( )Diabetes ( )Early Deaths ( )Hypertension

Additional Comments: Chronic illnesses in any siblings:_____

_____

PATIENT HISTORY

Known Allergies:_____ Birth Hospital:_____

OB Doctor:_____Condition at Birth:_____

Birth Weight:_____Additional Comments:_____

Are vaccines up to date? YES____ (If yes, please furnish immunization records at front desk) NO____ (If no, please indicate the earliest date at which you can summit records) _____.

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TB/Cholesterol Risk Assessment

Name:_____ Date:_____

TB Risk Factors (YES or NO)

1. Has your child been in contact with anyone who has tuberculosis? _____
2. Has your child ever had a positive PPD or Tuberculosis test? _____
3. Does your child have close contact with a person who had a positive TB skin test? _____
4. Was your child born outside of the United States? _____
5. Is anyone of your household members a recent immigrant from another county in the last 5 years? _____
6. Has your child or any member of your household traveled outside the US for more than a week? _____
7. Does your child spend time with anyone who has HIV or has been in jail in the last 5 years? _____
8. Has your child or any other member of your household lived in a shelter or group residence in the last 5 years? _____

Cholesterol Risk Factors (Patients 2 years of age and older)

9. Does either of the parents have cholesterol >240? _____
10. Has any member of your family had a heart attack or stroke before the age 55? _____

Person filling out this form:_____

Relationship to patient:_____

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Anemia/Lead Risk Assessment

Name:_____ Date:_____

Anemia Risk Factors

1. Is there a history of Anemia passed down in your family? _____
2. Does your baby drink something other than breast milk or a standard infant formula, for their regular feedings? (For infants 12 months of age or less) _____
3. Does your child (age 1yr and up) drink more than 24 ounces of milk each day, or still drink form a bottle? _____
4. Is your child (age 1yr and up) a strict vegetarian or an extremely picky eater? _____
5. Does your child suffer from chronic illness? _____

Lead Risk Factors (Patients 6 months to 6yrs of age)

1. Does your child live in a regularly visit home that was built before 1950? _____
2. Does your child live in a regularly visit home that was built before 1978 with recent construction or remodeling (within the last 6 months)? _____
3. Does your child have a sibling or a playmate that has been discharge with lead poisoning?_____
4. Does your child live or play near an active lead smelter, battery recycling plant or other industry likely to release lead into the environment? _____
5. Does your child live within one block of a major highway or busy street? _____
6. Have you ever seen your child **eating paint chips, soil, or dirt?** _____
7. Does your child eat food stored in leaded crystal, ceramic or pewter dishes? _____
8. Does your child have contract with candles, cosmetics, spices, or home/folk remedies made outside the US? _____
9. Has your child been exposed to any of the many recently recalled toys? _____

Person filling out this form:_____

Relationship to patient:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patients/Guardians:

We are required to provide you with a copy of our Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this form.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide KWP with my authorization and consent to use and disclose my child's protected healthcare information for the purpose of treatment, payment and healthcare operations as described in the Privacy Notice.

_____

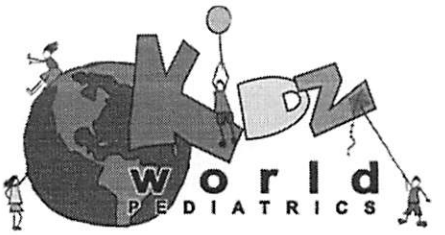
Patient's Name (please print)

_____ _____

Parent/Legal Guardian Name (please print) Date

_____ _____

Parent /Legal Guardian Signature Date



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MEDICAL RECORDS RELEASE FORM

Date:_____

PREV DR/FACILITY:_____Attn:_____

Telephone:_____Fax:_____

Patient's Name:_____D.O.B:_____

Patient's Name:_____D.O.B:_____

Patient's Name:_____D.O.B:_____

Patient's Name:_____D.O.B:_____

I,_____
(Please print Parent /Guardian's name)

Authorize_____
(Please write the name of the practice and/or Physician who previously attended your child)

To release my Son/Daughter's medical records (including HIV Information) to Dr. Hans Hubsch M.D.

_____
Parent/Legal Guardian Signature