Sawgrass Pediatrics

Michelle Snyder D.O – Lori Miller, M.D. – Anthony Martell, M.D. – Alina Di Liddo, M.D. – Jordan Mussary, M.D. – Alan Cadiz, D.O. Susan Shulman, D.O.

Paciente Nombre | **DOB** | **Fecha**

NACIMIENTO HISTORIA

¿Dónde nació su hijo? (Nombre del hospital o ciudad)

¿Cuál era su peso al nacer?

¿Era él / ella término completo? Sí ☐ No ☐
Si no es así, ¿cuántas semanas antes o después estaba?

¿Hubo alguna complicación durante el embarazo? Sí ☐ No ☐
En caso afirmativo, ¿cuáles eran?

Fue el parto de su hijo Vaginal ☐ C-sección ☐

¿Hubo alguna complicación durante el parto? Sí ☐ No ☐
En caso afirmativo, ¿cuáles eran?

¿Hubo alguna complicación para el bebé? Sí ☐ No ☐
En caso afirmativo, ¿cuáles eran?

¿Estaba el bebé en la UCIN (Unidad de Cuidados Intensivos para Recién Nacidos)? Sí ☐ No ☐
En caso afirmativo, ¿cuánto tiempo? ¿Y por qué estaba en la UCIN?

¿El bebé requirió fototerapia (terapia de luz) para la ictericia? Sí ☐ No ☐

MEDICAMENTOS

Tomar algún medicamento En caso afirmativo, ¿qué? (incluyendo vitaminas, medicamentos de venta libre y recetas) Sí ☐ No ☐

¿Alérgico a algún medicamento? En caso afirmativo, ¿qué medicamento(s) y qué reacción(es)? Sí ☐ No ☐

ALERGIAS

¿Alérgico a algún alimento? En caso afirmativo, ¿qué alimentos? Sí ☐ No ☐

¿Alérgico a cualquier cosa en el medio ambiente? En caso afirmativo, ¿a qué? Sí ☐ No ☐

¿Son estas alergias? Sospecha ☐ Definido(Probado) ☐

Por favor, describa cualquier otro nacimiento complications:

ENFERMEDADES PASADAS, HOSPITALIZACIONES

¿Alguna vez su hijo fue admitido en el hospital durante la noche? Si es así, ¿cuándo? ¿Para qué? Sí☐ No ☐

¿Alguna vez ha tenido que llevar a su hijo a la sala de emergencias? Sí ☐ No ☐
En caso afirmativo, ¿para qué?

Por favor, describa:

QUIRÚRGICO HISTORIA– ¿Alguna vez su hijo se ha sometido a una cirugía?? En caso afirmativo, marque las casillas individuales

Cabeza o Cráneo ☐	Dispositivo coclear ☐	☐	Pyloric Stenosis Repair ☐	Testicular Surgery ☐
Ojos ☐	Amígdalas ☐	Tubo torácico ☐	Kidney Surgery ☐	Torsion Reduction ☐
Orejas ☐	Adenoides ☐	Gastrointestinal ☐	Urological Surgery ☐	Undescended Testicle ☐
Lágrima Conducto Sonda ☐	Adenoides ☐	Endoscopia superior ☐	Circumcision ☐	Orthopedic Surgery ☐
Corrección del estrabismo ☐	Seno ☐	Colonoscopia ☐	Chordee Release ☐	Scoliosis ☐
Tubos para los oídos ☐	Cuello ☐	Cirugía Abdominal ☐	Hypospadias Repair ☐	Setting Bone Fracture ☐
Extracción del tubo auditivo ☐	Cirugía cardíaca ☐	Apendicectomía ☐	Hydrocele Repair ☐	Neurologic ☐
Reparación de tímpanos ☐	Pulmón Cirugía ☐	Inguinal Hernia Repair ☐	Meatoplasty ☐	Dermatologic/Skin ☐
Colesteotoma ☐	Broncoscopia ☐	Umbilical Hernia Repair ☐	Bladder Surgery ☐	

Problemas respiratorios ☐	Enfermedad renal/renal ☐	TrastornosTrastornos ☐	Depresión ☐	Por favor, describa
Asma ☐	Riñón poliquístico ☐	Anemia ☐	Trastornos genéticos ☐	
Neumonía ☐	Proteinuria ☐	Trastornos hemorrágicos ☐	☐	
Fibrosis quística ☐	Reflujo urinario ☐	Plaquetas bajas ☐	☐	

Cualquier otro historial médico pasado no mencionado

(Ver reverso para más preguntas)

Firma del padre/tutor **Fecha**

Sawgrass Pediatrics

FORMULARIO DE HISTORIAL DE SALUD (página 2)

FAMILIA HISTORIA En caso afirmativo, marque Incluya al PACIENTE, padres, abuelos, tías, tíos, hermanos, hermanas, primos hermanos
Si no hay antecedentes familiares de enfermedad, verifique Aquí ☐ (De lo contrario, marque las casillas individuales)

Enfermedad cardíaca ☐	Asma ☐	Enfermedad de Crohn ☐	Psiquiátrico No hay historial disponible ☐	No hay historial disponible ☐
Presión arterial alta ☐	Enfisema ☐	Hemorragia o Coagulación Defecto inmunológico ☐	TDA/TDAH ☐	Adoptivo ☐
Alto Colesterol ☐	Fibrosis Cística ☐	Defecto inmunológico ☐	Defectos de nacimiento ☐	☐
Diabetes Diabetes I (Niño) ☐	Tuberculosis ☐	Infección de VIH ☐	Cualquier otro historial médico pasado no mencionado	
Diabetes Tipo II (Adulto) ☐	Hepatitis ☐	Artritis ☐		
Cáncer ☐	Alergias ☐	Trastorno convulsivo ☐		
Tiroides Enfermedad ☐	Cirrosis de hígado ☐	Golpe ☐		
Nefropatía ☐	Colitis ulcerosa ☐	Trastorno neurológico ☐		

ANTECEDENTES SOCIALES

EL NIÑO VIVE CON	Ambos padres (casados) ☐	Guardián/Otro ☐	El niño vive en	MASCOTAS EN CASA
Madre ☐	Padre ☐	Abuelo(s) en el Hogar ☐	Casa ☐	Perro(s) ☐
Separado ☐	Separado ☐	Abuelo(s) como Guardián ☐	Apartamento/Condominio ☐	Gato(s) ☐
Divorciado ☐	Divorciado ☐			Ave(s) ☐
Custodia Compartida ☐	Custodia Compartida ☐	Otro Parentela en el Hogar ☐		Pescado(s) ☐
Custodia exclusiva ☐	Único Custodia ☐	Otro Parientes como Guardián ☐		Lagarto/Tortuga ☐
W/Padrastro ☐	W/Padrastro ☐	**Por favor Indicar Nombre de Guardián si Otro que Mamá o Papá:**		Otro
W/Hermanastro ☐	W/Hermanastro ☐			
W/Hermanastra ☐	W/Hermanastra ☐			
ocupaciónOocupación	**Padre Ocupación**			

ORIGEN ÉTNICO	LENGUA MATERNA	FUMAR/DROGAS/ALCOHOL		
Caucásico ☐	English ☐	¿Alguien fuma dentro o fuera de la casa?	Sí ☐	No ☐
Hispanic ☐	Spanish ☐	**PARA PACIENTES DE 13 AÑOS O MÁS**		
Afro-americano ☐	Criollo ☐	Antecedentes de consumo de drogas	Sí ☐	No ☐
Asiático ☐	Otros (especifíquese)	Antecedentes de consumo de alcohol	Sí ☐	No ☐
Amerindio ☐		Historia del consumo de tabaco	Sí ☐	No ☐
Haitiano ☐				
Otro ☐				

Información de farmacia: Todas las recetas se enviarán electrónicamente: ya no recibirá recetas en papel

Nombre y número de teléfono de su farmacia	Dirección o cruce de calles de su farmacia
Describa cualquier otro problema con su hijo en el que podamos ayudarlo:	

Firma del padre/tutor **Fecha**

TopLine MD Alliance

FORMULARIO DEMOGRÁFICO PEDIÁTRICO DE SAWGRASS

Información para el paciente

Nombre:_____ FECHA DE NACIMENTO: _____

APELLIDO PRIMERA

{HOMBRE} / {MUJER} **El niño varón reside con: {Padre} {Madre} {Ambos} {Otros:}**_____

Padre/Tutor

Nombre: _____ FECHA DE NACIMENTO: _____

Dirección: _____ Ciudad:_____

Estado: _____ Código Postal: _____ Teléfono principal: _____

Numero Celular: _____ Dirección de correo electrónico: _____

Idiomas hablados en casa: {Inglés} {Español} Otros: _____ Hermanos en la oficina: _____

_____

Otra información para padres Nombre: _____ Fecha de nacimiento: _____

Dirección (si es diferente de la anterior): _____

CONTACTO DE EMERGENCIA:_____ Numero de Telefono: _____

Información del titular de la póliza de seguro

Nombre del seguro: _____ Titular de la poliza: _____

Fecha de nacimiento: _____ Dirección (si es diferente de la anterior): _____

Ciudad:_____ Estado: _____ Código Postal: _____

ID de póliza asegurada:_____

Información de la farmacia: Nombre de la farmacia:_____

Número de teléfono:_____ Dirección:_____

Ciudad:_____ Estado: _____ Código Postal: _____

La hora de su cita se ha reservado solo para usted. Si no puede conservarlo, cancele con 24 horas de anticipación. Habrá un cargo de $ 50.00 por citas perdidas. Iniciales:_____

Por la presente autorizo el pago, directamente a Sawgrass Pediatric Partners, LLC de los beneficios que me debe mi compañía de seguros, de lo contrario me serían pagaderos. Además, autorizo la divulgación de cualquier información médica requerida por mi compañía de seguros. Entiendo que soy financieramente responsable de los cargos, trabajos de laboratorio y vacunas no cubiertos por mi contrato de seguro tal como se realizan en la oficina, y de cualquier copago y / o monto deducible especificado en mi contrato de seguro. Reconozco que el material de información de salud privada (HIPAA). se publica y está disponible bajo petición.

_____ _____ _____

Nombre del padre/paciente **Firma** **Fecha**

Sawgrass Pediatría

INFORMAR AL PACIENTE				
Apellido:	Primero:	Segundo Nombre:	☐ Hombre ☐ Hembra	Fecha de Nacimiento:

CONSENTIMIENTO PARA AMIGOS Y FAMILIARES

En el caso de que yo necesite tratamiento médico y no pueda dar mi consentimiento para mi propio tratamiento; o mi hijo necesite tratamiento médico y yo (o no su tutor legal) no pueda traer a mi hijo para su tratamiento:

☐ Yo,_____, autorizo a la(s) persona(s) siguiente(s) a buscar tratamiento médico para mí o mi hijo y a discutir la información de salud protegida (PHI) en la medida en que Sawgrass Pediatrics considere necesario para proporcionar atención.

Entiendo que esto podría incluir información como: diagnóstico, pronóstico y planes de tratamiento, medicación, instrucciones de alta y planes, resultados de pruebas de diagnóstico, recordatorios de citas, facturación médica, seguro y cualquier otra información médica relevante para el cuidado del paciente. Esta autorización seguirá siendo válida hasta que se produzca una nueva se ha completado la autorización o se ha recibido un preaviso de diez para revocar la autorización.

1. _____ _____ _____
Nombre | Relación con el paciente | Teléfono #

Además, la persona nombrada anteriormente puede:

☐ o Recoger recetas ☐ o Recoger documentos ☐ o Pregunte sobre Referencias
☐ o Hacer/ cambiar citas ☐ o Acceda a la información de seguro / facturación ☐ o Pregunte acerca de los resultados de las pruebas

2. _____ _____ _____
Nombre | Relación con el pacente | Teléfono #

Además, la persona nombrada anteriormente puede:

o Recoger recetas o Recoger documentos o Pregunte sobre Referencias
o Hacer/ cambiar citas o Acceda a la información de seguro / facturación o Pregunte acerca de los resultados de las pruebas

3. _____ _____ _____
Nombre | Relación con el número de | teléfono

Además, la persona nombrada anteriormente puede:

o Recoger recetas o Recoger documentos o Pregunte sobre Referencias
o Hacer/ cambiar citas o Acceda a la información de seguro / facturación o Pregunte acerca de los resultados de las pruebas

Nombre del paciente o tutor legal (imprimir):_____

Firma:_____ Fecha: _____

O

☐ Me niego a autorizar a nadie más a buscar tratamiento médico para mí o para mi hijo.

Nombre del tutor legal (imprimir):

Firma:_____ Fecha: _____

CONSENTIMIENTO PARA LA VOZ Y COMUNICACIÓN POR MENSAJES DE TEXTO

TopLine MD Alliance

En un esfuerzo por transmitir los resultados normales más rápido a nuestros pacientes, hemos implementado registros médicos electrónicos.

Entiendo que para que Sawgrass Pediatric Partners, LLC deje mensajes detallados que contengan información médica específica en mi correo de voz o contestador automático, debo dar mi permiso a Sawgrass Pediatric Partners, LLC.

Además, entiendo que para que Sawgrass Pediatric Partners, LLC envíe mensajes detallados que contengan información médica específica a mi teléfono celular, debo dar mi permiso expreso por escrito a Sawgrass Pediatric Partners, LLC, también entiendo que mi información de atención médica en Sawgrass Pediatric Partners, LLC está protegida y una copia del Aviso de prácticas de privacidad está disponible a mi solicitud.

Consentimiento para mensajes

Doy mi consentimiento expreso por escrito a Sawgrass Pediatric Partners, LLC para dejar mensajes detallados en mi correo de voz / texto / contestador automático sobre mis resultados normales de laboratorio, resultados de diagnóstico y / o imágenes, información de recetas o recordatorios de citas. No se comunicarán resultados anormales a través de nuestro sistema automatizado

AUTORIZO A SAWGRASS PEDIATRIC PARTNERS, LLC A ENVIAR COMUNICACIONES ELECTRÓNICAS AUTOMÁTICAS A TRAVÉS DE MENSAJES DE TEXTO / CORREO ELECTRÓNICO / CORREO DE VOZ

Nombre del paciente (Imprimir): _____

Padres/Pacientes Signature_____ **Móvil #:** _____

(Este número se utilizará para la mensajería)

Es mi responsabilidad mantener esta información actualizada, ya que reconozco que mi información puede cambiar con el tiempo. Este consentimiento se considerará válido hasta el momento en que lo revoque. Me reservo el derecho de revocarlo en cualquier momento. Entiendo que debo proporcionar un aviso por escrito para revocar este consentimiento

AUTORIZACIÓN PARA LANZAMIENTO Y DIVULGAR LOS REGISTROS MÉDICOS DE LOS PACIENTES

Sawgrass Pediatrics
TopLine MD Alliance

Información para el paciente

Nombre del paciente:_____ Fecha de nacimento:_____
Dirección:_____
Ciudad/Estado:_____ Código Postal: _____Numero de telefono:_____

¿Dónde desea que se envíen o soliciten los registros? ( ) Consultorio Médico ( ) Personal

Nombre/Médica:_____
Dirección:_____
Ciudad/Estado:_____ Código Postal: _____Numero de telefono:_____

INFORMACIÓN QUE SE DARÁ A CONOCER

*Yo,*_____ autorizar de antemano_____ a

- ☐ **Divulgar mi registro de salud completo, incluidos, entre otros, diagnósticos, resultados de pruebas de laboratorio, tratamientos o registros de facturación.**
- ☐ **Enfermedades transmisibles pero no limitadas a ( ) HIV y AIDS ( ) Otros:**_____
  _____

¿Cómo desea que se entregue la información? (La solicitud tarda de 7 a 10 días hábiles para su procesamiento)
( ) Correo ( ) Fax ( ) Recoger por:_____ (se aplican tarifas)

Propósito de la liberación(¿Por qué es necesario?)

- ☐ **Transferencia de la atención al nuevo médico**
- ☐ **Cambio de seguro**
- ☐ **Mudarse fuera del estado**
- ☐ **Copia personal (se aplican tarifas)**
- ☐ **Descontento con el servicio al cliente**
- ☐ **Descontento con la práctica (por favor, indique porqué?**_____
  _____
- ☐ **Otros:**_____

ATHORIZACIÓN PARA DIVULGAR INFORMACIÓN DE SALUD PROTEGIDA

Por la presente, autorizo el uso de la *divulgación* de *mi información de salud identificable individualmente* como *se describe. Entiendo que esta autorización es voluntario. Entiendo que el tratamiento, el pago, la inscripción o la elegibilidad* de *los beneficios* pueden *no estar condicionados a que firme esta autorización. Yo comprenda además que si la organización autorizada para recibir la información* no es *un plan de salud o proveedor de atención médica, el comunicado la información podría ser potencialmente divulgada de nuevo y ya no puede estar protegida por las regulaciones federales de privacidad. Por lo tanto, libero a Sawgrass Pediatric Partners, LLC de toda responsabilidad que surja de esta divulgación* de *mi información de salud. Entiendo y acepto que soy financieramente responsable de los siguientes honorarios asociados con mi solicitud: cargos de copia y franqueo relacionados con la producción* de *mi información. Para pacientes y entidades gubernamentales:*

Nombre del paciente:_____

Firma:_____
(Paciente, Padre, Tutor o Representante Legal)

***Ubicación de Coral Springs**: 9750 NW 33Rd Calle, Suite 101 Coral Springs, FL 33065 Tel: (954) 752-9220 Fax: (954)752-1549*
***Ubicación de Boca Raton**: 9801 Glades Road, Boca Ratón, FL 33434 Tel: (561) 487-9912 Número de fax: (561) 487-5070*

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SOLICITUD DE MEDICAID:

POR FAVOR VISITE: https://dcf-access.dcf.state.fl.us/access/index.do

O BÚSQUEDA EN GOOGLE: MY ACCESS FLORIDA.

HAGA CLIC EN: SOLICITAR BENEFICIOS Y COMPLETE LA SOLICITUD.

UNA VEZ COMPLETADO, ASEGÚRESE DE REVISAR SU CORREO ELECTRÓNICO DIARIAMENTE PARA OBTENER LA CARTA DE APROBACIÓN O DENEGACIÓN.

SI SE LE NIEGA MEDICAID, USTED SERÁ RESPONSABLE DE LAS VISITAS DE AUTOPAGO.

PLANES DE MEDICAID SOLO PARA ELEGIR	PLANES DE MEDICAID **QUE NO ACEPTAMOS:**
• **SIMPLY MEDICAID**	**- SUNSHINE MEDICAID**
• **COMMUNITY CARE MEDICAID**	**- HUMANA MEDICAID**
• **MOLINA MEDICAID**	**- PRESTIEGE MEDICAID**

UNA VEZ QUE HAYA SIDO APROBADO PARA MEDICAID EN EL PORTAL, LLAME A LA OFICINA DE MEDICAID Y ASIGNE A SU HIJO AL PLAN DE MEDICAIDS ANTERIOR. **PARRENDAMIENTO COMPLETE LOS PASOS A CONTINUACIÓN.**

1. Nombre del Plan de Medicaid _____
2. ID de miembro # _____

- **UNA VEZ QUE SE ASIGNE EL PLAN, COMUNÍQUESE CON LA COMPAÑÍA DE SEGUROS ACTUAL Y RETROCEDA EL FISICO ASIGNADO CON EL QUE ACTUALMENTE ESTÁ ESTABLECIENDO LA ATENCIÓN HASTA LA FECHA DE NACIMIENTO DEL BEBÉ. PÓNGASE EN CONTACTO CON SAWGRASS PEDIATRICS PARA DAR LOS SIGUIENTES 1-3 PASOS ANTES DE 30 DÍAS.**

3. REFRENCE # NÚMERO PARA PCP CAMBIO **RETRO A LA FECHA DE NACIMIENTO**. _____.

✓ UNA VEZ COMPLETADO, COMUNÍQUESE CON NUESTRA OFICINA Y HABLE CON NUESTRO DEPARTAMENTO DE VERIFICACIÓN CON TODA LA INFORMACIÓN OBTENIDA ANTERIORMENTE.

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HEALTH HISTORY FORM

Patient Name _____ **DOB** _____ **Date** _____

BIRTH HISTORY

Where was your child born? (Hospital Name or City)

What was his or her birth weight?

Was he/she full term? Yes ☐ No ☐
If not, how many weeks early or late was he/she?

Were there any complications during pregnancy? Yes ☐ No ☐
If yes, what were they?

Was the delivery of your child Vaginal ☐ C-section ☐

Were there any complications during delivery? Yes ☐ No ☐
If yes, what were they?

Were there any complications for the baby? Yes ☐ No ☐
If yes, what were they?

Was the baby in NICU (Newborn Intensive Care Unit)? Yes ☐ No ☐
If yes, how long? And why was he/she in NICU?

Did the baby require phototherapy (light therapy) for jaundice? Yes ☐ No ☐

MEDICATIONS

Taking any medications If yes, what? (including vitamins, over the counter medications and prescriptions) Yes ☐ No ☐

Allergic to any medications? If yes, what medication(s) and what reaction(s)? Yes ☐ No ☐

ALLERGIES

Allergic to any foods? If yes, what foods? Yes ☐ No ☐

Allergic to anything in the environment? If yes, to what? Yes ☐ No ☐

Are these allergies? Suspected ☐ Definite (Tested) ☐

Please describe any other birth complications:

PAST ILLNESSES, HOSPITALIZATIONS

Was your child ever admitted to the hospital overnight? If so, when? For what? Yes ☐ No ☐

Have you ever had to take your child to the emergency room? If yes, what for? Yes ☐ No ☐

Please describe:

SURGICAL HISTORY – Has your child ever had surgery? If yes please check the individual boxes

Head or Skull ☐	Cochlear Device ☐		☐	Pyloric Stenosis Repair ☐	Testicular Surgery ☐
Eyes ☐	Tonsils ☐	Chest Tube	☐	Kidney Surgery ☐	Torsion Reduction ☐
Ears ☐	Adenoids ☐	Gastrointestinal	☐	Urological Surgery ☐	Undescended Testicle ☐
Tear Duct Probe ☐	Oral Surgery ☐	Upper Endoscopy	☐	Circumcision ☐	Orthopedic Surgery ☐
Strabismus Correction ☐	Sinus ☐	Colonscopy	☐	Chordee Release ☐	Scoliosis ☐
Ear Tubes ☐	Neck ☐	Abdominal Surgery	☐	Hypospadias Repair ☐	Setting Bone Fracture ☐
Ear Tube Removal ☐	Heart Surgery ☐	Appendectomy	☐	Hydrocele Repair ☐	Neurologic ☐
Ear Drum Repair ☐	Lung Surgery ☐	Inguinal Hernia Repair	☐	Meatoplasty ☐	Dermatologic/Skin ☐
Cholesteatoma ☐	Brochoscopy ☐	Umbilical Hernia Repair	☐	Bladder Surgery ☐	

PAST MEDICAL HISTORY – If There is No Past Medical History Check Here ☐ (otherwise check the individual boxes)

Skin Problems ☐	Cardiac Problems ☐	Gynecologic Issues ☐	Neurological Disorders ☐	Has your child had a poistive PPD Test ☐
Acne ☐	Murmurs ☐	Rheumatology Disorders ☐	Headaches ☐	
Eczema ☐	Heart Defects ☐	Rheumatoid Arthritis ☐	Febrile Seizures ☐	Oncology Disease (Cancer)
Eye/Vision Problems ☐	High Cholesterol ☐	Lupus ☐	Epilepsy ☐	
Glasses for Reading ☐	Stomach Intestinal Disorders ☐	Endocrine Disorders ☐	Developmental Delay ☐	
Glasses for Distance ☐	GERD (Heartburn) ☐	Diabetes Type I (Child) ☐	Speech/Language Delay ☐	
Ear/Nose/Throat ☐	Constipation ☐	Diabetes Type II (Adult) ☐	Fine Motor Delay ☐	Please Describe
Recurrent Ear Infections ☐	Irritable Bowel ☐	Thyroid Disease ☐	Social Delay ☐	
Recurrent Sinus Infections ☐	Ulcerative Colitis ☐	Orthopedic Disorders ☐	Cognitive Delay ☐	
Hearing Loss ☐	Crohn's Disease ☐	Fractures in the Past ☐	Psychiatric Disorders ☐	
Allergies ☐	Pyloric Stenosis ☐	Scoliosis ☐	ADD/ADHD ☐	Immune Disorders ☐
Respiratory Problems ☐	Renal/Kidney Disease ☐	Blood Disorders ☐	Depression ☐	Please Describe
Asthma ☐	Polycystic Kidney ☐	Anemia ☐	Genetic Disorders ☐	
Pneumonia ☐	Proteinuria ☐	Bleeding Disorders ☐	☐	
Cystic Fibrosis ☐	Urine Reflux ☐	Low Platelets ☐	☐	

Any Other Past Medical History Not Mentioned

(See Reverse Side For More Questions)

Sawgrass Pediatrics

HEALTH HISTORY FORM (page 2) DOB:

FAMILY HISTORY If yes please check Please include the PATIENT'S, parents, grandparents, aunts, uncles, brothers, sisters, first cousins

If There is No Family History of Disease Check Here ☐ (otherwise check the individual boxes)

Heart Disease ☐	Asthma ☐	Crohn's Disease ☐	Psychiatric Disorder ☐	No History Available ☐
High Blood Pressure ☐	Emphysema ☐	Bleeding or Clotting Disorder ☐	ADD/ADHD ☐	Adopted ☐
High Cholesterol ☐	Cystic Fibrosis ☐	Immune Defect ☐	Birth Defects ☐	☐
Diabetes Type I (Child) ☐	Tuberculosis ☐	HIV Infection ☐	Any Other Past Medical History Not Mentioned	
Diabetes Type II (Adult) ☐	Hepatitis ☐	Arthritis ☐		
Cancer ☐	Allergies ☐	Seizure Disorder ☐		
Thyroid Disease ☐	Cirrhosis of the liver ☐	Stroke ☐		
Kidney Disease ☐	Ulcerative Colitis ☐	Neurologic Disorder ☐		

SOCIAL BACKGROUND

CHILD LIVES WITH	Both Parents (Married) ☐	Guardian/Other ☐	Child Lives In	PETS AT HOME
Mother ☐	Father ☐	Grandparent(s) in the Home ☐	House ☐	Dogs (s) ☐
Separated ☐	Separated ☐	Grandparent(s) as Guardian ☐	Apartment/Condo ☐	Cat (s) ☐
Divorced ☐	Divorced ☐			Bird (s) ☐
Joint Custody ☐	Joint Custody ☐	Other Relatives in the Home ☐		Fish (s) ☐
Sole Custody ☐	Sole Custody ☐	Other Relatives as Guardian ☐		Lizard/Turtle ☐
W/Stepfather ☐	W/Stepfather ☐	Please Indicate Name of Guardian if other than Mom or Dad:		Other
W/Stepbrother ☐	W/Stepbrother ☐			
W/Stepsister ☐	W/Stepsister ☐			
Mother's Occupation	Father's Occupation			

ETHNIC BACKGROUND	NATIVE LANGUAGE	SMOKING/DRUGS/ALCOHOL		
Caucasian ☐	English ☐	Does anyone smoke inside or outside the house?	Yes ☐	No ☐
Hispanic ☐	Spanish ☐			
African American ☐	Creole ☐	**FOR PATIENTS 13 OR OLDER**		
Asian ☐	Other (please specify)	History of Drug Use	Yes ☐	No ☐
American Indian ☐		History of Alcohol Use	Yes ☐	No ☐
Haitian ☐		History of Tobacco Use	Yes ☐	No ☐
Other ☐				

Pharmacy Information: All Prescriptions will be sent electronically – you will no longer receive paper prescriptions

Name and Phone Number of your Pharmacy	Address or Cross Streets of your Pharmacy

Please describe any other problems with your child where we may be able to help:

Parent/Guardian Signature **Date**

TopLine MD Alliance

SAWGRASS PEDIATRIC DEMOGRAPHIC FORM

Patient Information

Name:_____ _____ Date of Birth:_____
Last First

Male Female **Child Resides With: Father Mother Both Other:** _____

Parent/Guardian

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Primary Phone: _____ Alternate Phone: _____

Email Address: _____

Languages spoken at home: English Spanish Other: _____

Siblings in the office: _____

Other Parent Information Name: _____ Date of Birth: _____

Address (If different from above): _____ City: _____ State:_____
Primary Phone :_____ Alternate Phone:_____

EMERGENCY CONTACT:_____ **Phone Number:**_____

Insurance Policy Holder Information

Insurance Name: _____ Policy Holder:_____ DOB:_____

Address (If different from above): _____ City:_____State:_____
Zip Code:_____ Phone Number: _____Employer:_____

Insured Policy ID:_____ Address:_____

Pharmacy Information: Pharmacy Name:_____

Phone number:_____ **Address:**_____

City, State, Zip _____

Your appointment time has been set aside for you alone. If you can't keep it, kindly cancel 24 hours in advance. There will be a $50.00 charge for missed appointments. Initials:_____

I hereby authorize payment, directly to Sawgrass 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 specified in my insurance contract. I acknowledge that Private Health Information material (HIPAA). is posted, and available upon request.

_____ _____ _____

Parent/Patient's Name **Signature** **Date**

Sawgrass Pediatrics

PATIENT INFORMATION				
Last Name:	First:	Middle:	☐ Male ☐ Female	Birth Date:

CONSENT FOR FRIENDS AND FAMILY

In the event that I am in need of medical treatment and unable to consent for my own treatment; or my child is in need of medical treatment and I (or another legal guardian) am unable to bring in my child for treatment:

☐ I, _____, authorize the following person(s) to seek medical treatment for me or my child and to discuss protected health information (PHI) to the extent Sawgrass Pediatrics deems necessary to provide care.
I understand that this might include such information as: diagnosis, prognosis and treatment plans, medication, discharge instructions and plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to the care of the patient. This authorization will remain valid until a new authorization is completed or until written notice to revoke the authorization is received.

1. _____ (Name) _____ (Relationship to patient) _____ (Telephone #)

Additionally, the individual named above may:
☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

2. _____ (Name) _____ (Relationship to patient) _____ (Telephone #)

Additionally, the individual named above may:
☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

3. _____ (Name) _____ (Relationship to patient) _____ (Telephone #)

Additionally, the individual named above may:
☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

Name of Patient or Legal Guardian (print): _____

Signature: _____ Date: _____

OR

☐ I decline to authorize anyone else to seek medical treatment for me or my child.
Name of Legal Guardian (print): _____

Signature: _____ Date: _____

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

In an effort to relay Normal results faster to our patients we have implemented Electronic Medical Records.

I understand that in order for Sawgrass Pediatric Partners, LLC to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Sawgrass Pediatric Partners, LLC.

I further understand that in order for Sawgrass Pediatric Partners, LLC to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Sawgrass Pediatric Partners, LLC I also understand that my healthcare information at Sawgrass Pediatric Partners, LLC is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages

I give my written express consent to Sawgrass Pediatric Partners, LLC to leave detailed messages on my voicemail/ text/answering machine about my normal lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system

☐ **I AUTHORIZE SAWGRASS PEDIATRIC PARTNERS, LLC TO SEND AUTOMATIC ELECTRONIC COMMUNICATION VIA TEXT/EMAIL/VOICEMAIL MESSAGES**

☐ **I DECLINE TO AUTHORIZE SAWGRASS PEDIATRIC PARTNERS,LLC TO SEND AUTOMATIC ELCTRONIC COMMUNICATION VIA TEXT/EMAIL/VOICEMAIL MESSAGES.**

Patient Name (Print) : _____ **Date :** _____

Parent/Patient Signature _____ **Mobile # :** _____

(This number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT MEDICAL RECORDS

Patient Information

Patient's Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Day Phone #:_____

Where do you want the records to be sent or requested? ( ) Physician Office ( ) Self

Name/Physcian:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

INFORMATION TO BE RELEASED

*I*_____ *hereby authorize* _____ *to*

- ☐ **Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatments or billing records.**
- ☐ **Communicable disease but not limited to ( ) HIV and Aids ( ) Other:**_____

_____

How do you want the information delivered?(Request take 7-10 business days for processing)
( ) Mail ( ) Fax ( ) Pick up by:_____**(fees apply)**

Purpose of Release(Why is it needed?)

- ☐ **Transfer of care to new physician**
- ☐ **Change of insurance**
- ☐ **Moving out of state**
- ☐ **Personal Copy (fees apply)**
- ☐ **Unhappy with Customer Service**
- ☐ **Unhappy with practice (Please state why?**_____

_____

- ☐ **Other:**_____

_____

ATHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Sawgrass Pediatric Partners, LLC from all liability arising from this disclosure of my health information. I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. For patients and governmental entities:

Patient Name:_____ Date:_____

Signature:_____

(Patient, Parent, Guardian or Legal Representative)

***Coral Springs Location**: 9750 NW 33rd Street, Suite 101 Coral Springs, FL 33065 Tel: (954) 752-9220 Fax: (954)752-1549*

***Boca Raton Location**: 9801 Glades Road, Boca Raton, FL 33434 Tel: (561) 487-9912 Fax: (561) 487-5070*

FINANCIAL POLICY

Thank you for choosing Sawgrass Pediatric Partners, LLC as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner; you will be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service.

Noncovered Services: Please be aware that some of the services received may not be covered. Please contact your insurance provider for all questions regarding non covered services. Please contact your provider, services, Or policy specific.

DEDUCTIBLE PAYMENT: A deposit payment will be collected before each visit; additional charges may apply depending on tests performed and or the severity of the evaluation and management of care given.

TELEMEDICINE: This is a remote office visit offered under special circumstanced approved by the Physician. Applicable fees are due at time of service.

SELF-PAY: A deposit for a "minimal office visit" will be collected before each visit; additional charges may apply depending on tests performed and or the severity of the evaluation and management of care given at that visit.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from-us, your primary care physician if your insurance carrier requires it for your visits. Please allow 48- 72 hours for processing referrals.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

WELL VISITS: This visit is a routine physical exam which addresses preventative care and health maintenance and is billed as such. All parents must agree to the administration of Childhood vaccinations and follow the recommended guidelines. Additionally, the American Academy of Pediatrics recommends Behavioral and Developmental testing be administered at selected Well visits. These important tests may not be covered fully by your insurance plan and may become the "Guarantor's responsibility." Please ask your insurance carrier for details..

SICK/WELL VISITS: This is a combination visit of a routine physical exam where an acute or chronic issue is addressed as well. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a combination visit and must be billed differently than just a well visit or just a sick visit..

WHY IT IS BILLED DIFFERENTLY: It is billed differently to account for the additional work, expertise and time required for a combination visit (additional lab work, referrals and/or prescription medications). It involves additional documentation as well.

WALK-IN: Our appointments are given based on a schedule. Patients' who walk in will be triaged and seen for urgent care if necessary. If deemed non-urgent, the next available appointment time will be offered.

LATENESS: Patients arriving after their scheduled appointment time may need to be rescheduled at the Physician's discretion.

AFTER HOURS VISITS: This appointment is offered after 5:00 p.m. or on Saturday. These appointments are available for added convenience or emergencies and are billed as such. You may incur an additional fee for this appointment depending on your individual Insurance plan. Missed appointments that are not canceled within 24 hours of your scheduled time will result in a $50.00 no show charge. We encourage you to check with your insurance company to confirm your coverage for all types of doctor visits.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $25.00 NSF fee from the office.

CONVIENCE FEES: **There is a flat fee of $10.00 for each set of schools and sports forms the office completes.**

I HAVE READ AND FULLY UNDERSTAND the financial policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name_____ **Patient date of Birth**_____

Responsible Party Signature_____ **Today's Date**_____

Sawgrass Pediatrics

Michelle Snyder, D.O. - Lori Miller, M.D. - Anthony Martell, M.D. - Alina Di Liddo, M.D. - Jordan Mussary, M.D. - Alan Cadiz, D.O. Susan Shulman, D.O.

APPLYING FOR MEDICAID:

PLEASE VISIT: https://dcf-access.dcf.state.fl.us/access/index.do

OR GOOGLE SEARCH: MY ACCESS FLORIDA.

CLICK ON: APPLY FOR BENEFITS AND COMPLETE THE APPLICATION.

ONCE COMPLETED, BE SURE TO CHECK YOUR EMAIL DAILY FOR THE APPROVAL OR DENIAL LETTER.

IF MEDICAID IS DENIED YOU WILL BE RESPONSIBLE FOR SELF PAY VISITS.

MEDICAID PLANS ONLY TO CHOOSE FROM	MEDICAID PLANS WE **DO NOT ACCEPT:**
• **SIMPLY MEDICAID**	**- SUNSHINE MEDICAID**
• **COMMUNITY CARE MEDICAID**	**- HUMANA MEDICAID**
• **MOLINA MEDICAID**	**- PRESTIEGE MEDICAID**

ONCE YOU HAVE BEEN APPROVED FOR MEDICAID ON THE PORTAL, PLEASE CALL THE MEDICAID OFFICE AND ASSIGN YOUR CHILD TO THE MEDICAID PLANS ABOVE. **PLEASE COMPLETE THE BELOW STEPS.**

1. Name of Medicaid Plan _____.
2. Member ID # _____.

- **ONCE PLAN IS ASSIGNED, CONTACT THE CURRENT INSURANCE COMPANY AND RETRO THE ASSIGNED PHYSCIAN YOU ARE CURRENTLY ESTABLISHING CARE WITH BACK TO THE BABY DATE OF BIRTH. CONTACT SAWGRASS PEDIATRICS TO GIVE THE FOLLOWING 1-3 STEPS BEFORE 30 DAYS.**

3. REFRENCE # NUMBER FOR PCP CHANGE **RETRO BACK TO DATE OF BIRTH**

_____.

✓ ONCE COMPLETED PLEASE CONTACT OUR OFFICE AND SPEAK TO OUR VERFICATION DEPARTMENT WITH ALL OF THE INFORMATION OBTAINED ABOVE.

Notice of Privacy Practices
Sawgrass Pediatric Partners, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

9750 North West 33rd Street, Suite 101
Coral Springs, FL, 33065
(954) 752-9220

Please sign the accompanying "Acknowledgement" form