# 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 : ______________________________________________________________________

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: _________________________

**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 $ 15 charge for missed appointments. Initials: ____________________***

I hereby authorize payment, directly to Kendall Pediatric Associates, 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 Acknowledgement

KENDALL PEDIATRIC PARTNERS

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

For 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 PEDIATRICS**

Phone: (305) 274-2255 | 11400 N. Kendall Dr., A-211
Fax: (305) 274-2211 | Miami, FL 33176

## MEDICAL RECORDS RELEASE REQUEST

Doctor: ______________________________

Phone: ______________________________

Fax: ______________________________

Please release to Dr. Llosa all medical records in your possession on:

Patient Name: ______________________________

DOB: ______________________________

Address: ______________________________

______________________________

Home Phone: ______________ Work Phone: ______________

Parent/Guardian Signature: ______________________________

Parent/Guardian Name: ______________________________

Witness Signature: ______________________________

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

Date: ______________________________

Thank you for your attention to this matter.

# CHILD HEALTH HISTORY

Allergies: Home Phone#: Cell Phone #:

| DATE: | NAME PARENT/GUARDIAN: | SIBLINGS: | CARETAKERS: |
|---|---|---|---|

**MEDICAL HISTORY**

| Y = Yes, N = No, ? = Unknown | Patient | Family |
|---|---|---|
| Stroke/Hypertension | Y / N / ? | Y / N / ? |
| Heart Dz / Rheumatic Fever | Y / N / ? | Y / N / ? |
| Diabetes | Y / N / ? | Y / N / ? |
| Cancer | Y / N / ? | Y / N / ? |
| Congenital / Genetic Disorders | Y / N / ? | Y / N / ? |
| Blood Disorders / Sickle Cell / Rh | Y / N / ? | Y / N / ? |
| Lung / Tuberculosis / Asthma | Y / N / ? | Y / N / ? |
| Headaches / Seizures | Y / N / ? | Y / N / ? |
| Neuro / Mental / Emotional Heath | Y / N / ? | Y / N / ? |
| Breast Disease | Y / N / ? | Y / N / ? |
| Gall Bladder / Liver | Y / N / ? | Y / N / ? |
| Kidney / UTI | Y / N / ? | Y / N / ? |
| GI Disease | Y / N / ? | Y / N / ? |
| Substance Abuse | Y / N / ? | Y / N / ? |
| HIV | Y / N / ? | Y / N / ? |
| Skin / Skeletal | Y / N / ? | Y / N / ? |
| Thyroid / Endocrine | Y / N / ? | Y / N / ? |

**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):**

**FREQUENT EPISODES OF MINOR ILLNESS:**

**MEDICATIONS:**

**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 | |

| | | YES | NO |
|---|---|---|---|
| 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______________ |

| | | YES | NO |
|---|---|---|---|
| 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.