Ana M. Hernandez-Puga MD
9220 SW 72 ST #102
Miami, FL 33173
Tel: 305-275-1700
Fax:1-888-569-3931

PATIENT INFORMATION

Date: _____

(Please list all children in the family even if the child is not being seen today)

	Child 1	Child 2	Child 3	Child 4	Child 5
Last Name					
First Name					
Middle					
DOB					

PARENTAL INFORMATION

MOTHER/LEGAL GUARDIAN

Name_____
DOB _____ SSN# _____
Mailing Address _____
_____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer _____
Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Preferred Language_____
Step Father _____

FATHER/LEGAL GUARDIAN

Name_____
DOB _____ SSN# _____
Mailing Address _____
_____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer _____
Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Preferred Language_____
Step Mother _____

Pharmacy Name _____ Address _____Phone # _____
Who do the children reside with? ☐ Both ☐ Father ☐ Mother ☐ Other _____
Who has legal custody of child/children? ☐ Both ☐ Father ☐ Mother ☐ Other _____
Please provide any applicable legal documents.

Who is responsible for the medical bills? ☐ Father ☐ Mother ☐ Other _____
Which phone # should we list as your primary contact? _____ Is it ok to leave a message at this #?_____
For patients over the age of 18: What is <u>your</u> preference in communication? _____Is it ok to email you? _____
☐ Phone _____ ☐ Email_____

INSURANCE INFORMATION

PLEASE NOTE: YOU WILL BE ASKED TO PRESENT YOUR INSURANCE CARD AT **<u>EVERY</u> VISIT**

PRIMARY INSURANCE

Insurance Company_____
Insurance Effective Date_____
Insured's Name_____
Insured's DOB_____
ID#_____ Group#_____
Employer_____

SECONDARY INSURANCE

Insurance Company_____
Insurance Effective Date_____
Insured's Name_____
Insured's DOB_____
ID#_____ Group#_____
Employer_____

EMERGENCY CONTACT (Other than Parent)

Name_____ Relationship _____
Home Phone_____ Cell Phone _____ Work Phone _____

Signature of Parent/Guardian: _____ **Date:** _____

How did you hear about our practice? ☐ Yellow Pages Online ☐ RTP Links ☐ Friend/Family/Neighbor ☐ Other Physician
☐ Online (name of website) _____ ☐ Other _____

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PATIENT'S NAME:_____ DATE OF BIRTH:_____

ACKNOWLEDGEMENT OF HIPAA RIGHTS

_____ I do hereby acknowledge that AnaHP MD LLC has provided me with a notice of the privacy practice, as required by the Federal HIPAA Law. I understand that I will be provided a copy of the Policy, upon my request. I understand the Privacy Practices are posted on www.doctoranahp.com.

_____ I authorize for AnaHP MD LLC to leave medical information on voicemail at the phone numbers listed on my child's account.

RELEASE OF INFORMATION

_____ I authorize the release of any medical information necessary to process a claim

_____ I authorize payment of medical benefits to myself or the named provider of professional services rendered.

PARENTAL AUTHORIZATION TO TREAT MINOR CHILDREN

WHEN ACCOMPANIED OR NOT ACCOMPANIED BY PARENT OR GUARDIAN

_____ Yes, my child may be treated with Parent or Guardian

_____ Yes, my child may be treated when accompanied by:

Name	Relationship	Name	Relationship

_____ Yes _____ No My child over 16 years old may present and be treated unaccompanied by an adult.

Signature of Parent or Legal Guardian _____ Date:_____

Ana M. Hernandez-Puga. M.D.
9220 SW 72 St. Suite 102
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Patient Medical History

Name: _____ Birth Date: _____

Pregnancy History: *please circle if yes*

Took Medications Took other drugs Alcohol Smoking Vaginal infections Urine infections
Hypertension Diabetes Other problems: _____

Birth history: *Circle one:* full term pregnancy Premature birth at _____ weeks Adopted- at what age? _____
Has he/she been told he's adopted? _____

What hospital was baby born at? _____ Was the delivery vaginal? _____

What was baby's birth weight? _____Length? _____

Did the baby have any problems? If yes, please describe:

_____

Feeding: *(circle one)* breast fed bottle fed both

Past illnesses, surgeries, hospitalizations: *Has your child ever had (please circle)?*

More than 2 ear infections Heart problems Chickenpox Any major illness Kidney/ urinary tract infection

More than 2 strep infections Pneumonia Wheezing/asthma/bronchitis Hepatitis

Broken bones Convulsions Reactions to any immunizations or medications

Has your child ever been hospitalized overnight? Please describe:_____

Has your child ever had surgery? Please describe: _____

Has your child gone to an ER in the last year? Please describe: _____

Does your child have any allergies? Yes or No If yes to what? _____

Does your child have regular dental care? _____

Is your child on medications? Yes or no If yes please list: _____

Family History: *Please circle if close blood relative has the following:*

Allergies Cancer Emotional problems Learning Problems Strokes Tuberculosis

Anemia Convulsions/epilepsy Heart disease before age 50 Mental retardation (ex. down syndrome)

Asthma/bronchitis Cystic Fibrosis High blood pressure Migraines Tay Sachs/ metabolic disease

Birth defects Diabetes Kidney disease Muscular dystrophy Thyroid disease

Other illnesses: _____

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"Under Florida law, physicians are generally required to carry medical malpractice insurance otherwise demonstrate responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fails to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided to pursuant to Florida law."

Signature: _____

Patient name: _____

Date: _____

Ana M. Hernandez-Puga, MD

Notice of Policies

Payment Policy

Please be prepared to present your insurance card and Identification Card at every visit. Ensure that our pediatricians actively participate with your insurance carrier. Be aware of your insurance policy benefits and limitations. Make sure your insurance is current and active before your arrival. If we cannot verify coverage or there are services rendered that are not covered by your policy, it is your responsibility to pay in full at the time of the visit. All insurance co-payments and deductibles must be paid at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, Checks, and Cash.

Patients may receive and are responsible for bills for services sent to another facility such as a laboratory or diagnostic center which may not be covered by the insurance. Patients will be responsible for any bills of unpaid services including services that may have been denied or non-covered by your insurance carrier. Patients will be responsible for paying claims where either the practice or the insurance plan failed to receive accurate patient information. Statements will be mailed for unpaid services. If a balance is due over 90 days and we have not been contacted to arrange payments, the account may be turned over to a collection agency. Please notify us if you are experiencing financial difficulty and we will work with you on developing a payment plan.

We occasionally have parents who are divorced and the court makes one party responsible for all or part of the payments due. We will collect the entire amount due at the time of the visit. We will issue receipts so that one parent can obtain reimbursement from the other.

Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) alone with a $25 late fee. After the second episode of returned check, we will only accept cash or credit card as a form of payment.

Additional Fees

There will be a $10.00 fee for each sheet of Florida Department of Health School Entry Health Exam and Certification of Immunization ("Blue and Yellow" Forms.) WIC forms are $5 each. There are additional forms that may need to be completed such as sports clearance forms, summer camp forms, allergy forms for school, etc. Please note our policy is $10 per sheet completed by nurse or doctor. A copy of medical records released to a patient will have a fee of a $1 per page. Ear piercing performed by the physician will be charged $100.00 with a set of earrings included.

Late/Missed Appointment Policy

We appreciate a 24 hour notice on cancellations. This allows the office time to fill the empty appointment slot with someone else that needs to be seen. Missed appointments that are NOT cancelled the day before the scheduled appointment will incur a fee of $25 or your co-payment, whichever is higher. We will try to accommodate any sick patient who arrives late with the next available open appointment.

Walk-In Policy

We see all patients by appointments and offer same day appointment scheduling. Unless deemed urgent, patients who arrive without an appointment will be given the next available open appointment.

Referral Policy

Many insurance companies require authorization through your pediatrician before seeing a specialist. This process can take up to 5 business days to complete. If your pediatrician believes your child should see a specialist, call the specialist, confirm the doctor is on your insurance plan, and make an appointment. Call our office back with the name of the specialist, the appointment date, and time. Allow 3-5 business days for the completion of your referral.

Prescription Refill Policy

Prescription refill requests should be phoned in during regular office hours. Provide all pertinent information including the patient's name, date of birth, medication name, dose, pharmacy name, pharmacy address and phone number. Allow up to 3 business days for us to prepare the prescription. Certain chronic and recurrent conditions may require a visit for re-evaluation before a refill is provided. We do not call in or refill antibiotics or oral steroids without having seen the patient first.

Thank you for understanding our policies. Please let us know if you have any questions.

I have received and read a copy of Ana M. Hernandez-Puga, MD's Policies and agree to abide by them:

_____ / _____

Signature of Responsible Party Date