Date: ________/________/____________

NEW PATIENT FORM

How did you hear about us? Please be as detailed as possible: ____

PATIENT INFORMATION:

Last Name:____ First Name:____ M.I.______________

Date of Birth: ________________________ Gender: ___ Male ___ Female Primary Language: ____________________________________

Ethnicity: __ Hispanic __ Non-Hispanic __ Unknown

Home Address: ____ City: __________________ State:________ Zip:_________________

Home phone:_____________________________ cell phone : ______________________________________

CONTACT INFORMATION:

Contact 1:

Name: ____ Relation to Patient: __ Mother __ Father __Other: ________________________

Lives with Patient? __ Yes __No DOB:_________/_________/___________ Social Security #: __________-________-____________

Cell Phone: ____(_______)_________________________ Work Phone: ____(_______)___________________________

Employer: ____ Occupation: ____

Home E-Mail: ____

Contact 2:

Name: ____ Relation to Patient: __Mother __Father __Other: ________________________

Lives with Patient? __Yes __No DOB:_________/_________/___________ Social Security #: __________-________-____________

Cell Phone: ____(_______)_________________________ Work Phone: ____(_______)___________________________

Employer: ____ Occupation: ____

Home E-Mail: ____

EMERGENCY CONTACTS:

Contact 1:

Name of friend/relative (not living at same address): ____ Relationship:__________________________________

Home Phone: ___(_______)___________________ Cell Phone: ___(_______)_____________________ Work Phone: ___(_______)________________________

Contact2:

Name of friend/relative (not living at same address): ____ Relationship:__________________________________

Home Phone: ___(_______)___________________ Cell Phone: ___(_______)_____________________ Work Phone: ___(_______)________________________

INSURANCE INFORMATION:

Primary Policy

Policy Holder's Name: _____________________________ Policy Holder's Date of Birth: ________/________/_________ Policy Holder's Gender: __M __F

Insurance Carrier: _______________________________________ I.D. #:__________________________________ Group #:_______________________________

Secondary Policy

Policy Holder's Name: _____________________________ Policy Holder's Date of Birth: ________/________/_________ Policy Holder's Gender: __M __F

Insurance Carrier: _______________________________________ I.D. #:__________________________________ Group #:_______________________________

NEWBORN INSURANCE COVERAGE: *If your child is not a newborn, please skip this section.*

If you have not already, please notify your insurance company of the arrival of your newborn as soon as possible. Most insurance plans, including Medicaid, require immediate notification. Failure to do so could result in non-payment of filed claims. By signing below, I understand that I will be responsible for full payment of services should my insurance company deny payment.

Patient Name: ____ Date of Birth: __________/____________/_________________________

Parent/ Guardian Name: _____________________________________ Parent Guarding Signature: _______________________________ Date:____/______/______

Witness: ____ Date: _______/___________/____

BILLING:

Who should receive the billing statements? __Mother __Father __Other: ____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I certify that the above information is true and correct. I authorize my insurance benefits be paid directly to the physician/practice. I understand that I am financially responsible for any balance that my insurance does not cover. I also authorize Tuka Pediatrics or my insurance company to release any information to process my claims. I understand that there is a $35 service charge for all returned checks.

Parent/Guardian Signature:____ Today's Date: __________/___________/_________________

Print Name: ____ Relationship to Patient: ________________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____ Date of Birth: ___________/__________/_________________

Information requested from:

Person/Facility:____ Phone: ____(________)___________________________________

Address: ____ Fax: ____(_______)_______________________________________

**** Please only fax a maximum of 25 pages. If more than 25 pages, please mail to our office. Thank you! ****

Information may be disclosed to:

Person/ Facility: Tuka Pediatrics **Phone: (904) 222-6364**

Address: 4125 race track road unit 104 , ST Johns Fl 32259

Fax: 904-342-0442

For the purpose of:

__Continuity of Care __Personal Use __Other: ____

Information to be disclosed (via fax or mail):

__General Medical Records __Medical History __Physical Results __Progress Notes

__Diagnostic Test Results __Immunization Records __Consultation Notes __Other:______________________________

Please initial the statement below:

__________ These records may include information relating to: Sexually transmitted Diseases, HIV/AIDS, Tuberculosis, drug or alcohol abuse, pregnancy, mental health, child abuse, early intervention, and/ or WIC eligibility.

The authorization will expire on ______________________. I understand that if I fail to specify an expiration date, this authorization signature will expire (6) months from the date on which it was signed.

Parent/Guardian Signature:____ Todays Date: ____

Print Name: ____ Relationship to Patient:_________________________________

Witness:____ Date: ____

*** As a courtesy, please no discs. Thank you! ***

HEALTHCARE STATUS AUTHORIZATION

I, ____ (Parent or legal guardian), hereby give authorization to Tuka Pediatrics for the release of information concerning the status of my child's care, including laboratory and imaging results to provide medical services and treatment to:

Patients Name: ____ Date of Birth: _________/_________/____________

While they are accompanied by the following individual(s) in my absence:

Name: ____ Relationship to Patient: ________________________________

Address: ____

Home Phone: (_________) __________________________________ Cell Phone: (_________) ____________________________________

Name: ____ Relationship to Patient: ________________________________

Address: ____

Home Phone: (_________) __________________________________ Cell Phone: (_________) ____________________________________

Name: ____ Relationship to Patient: ________________________________

Address: ____

Home Phone: (_________) __________________________________ Cell Phone: (_________) ____________________________________

Name: ____ Relationship to Patient: ________________________________

Address: ____

Home Phone: (_________) __________________________________ Cell Phone: (_________) ____________________________________

May all contacts have access to patient's records electronically? __Yes __No

If parents are divorced or separated, please fill out the section below:

Who has custody of the child? __Mother __Father __Other: ____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? __Yes __No

If yes, please explain and provide a copy of the legal paperwork that supports this restriction:

____

____

____

Patients Name: ____________________________ Patients DOB: _____/_____/______ Gender: __M __F Is Child Adopted? __No __Yes

PATIENT'S PAST MEDICAL HISTORY

Condition	YES	NO	Comments
Comments			
Serious Injuries or Accidents			
Hospitalizations or ER Visits			
Surgeries			
Problems with Ears or Hearing			
Asthma / Bronchitis / Bronchiolitis / or Pneumonia (circle which applies)			
Indoor Allergens / Outdoor Allergens (circle which applies)			
ADD/ ADHD			
Heart Problems or Heart Murmur			
Anemia or Bleeding Problem			
Blood Transfusion			
Frequent Abdominal Pain			
Constipation Requiring Doctors Visits			
Bladder or Kidney Infection			
Bed Wetting (After 5 Years of Age)			
If Female patient, Have Menstrual Periods Started?			
If Female patient, Any Problems with Period? (cramping, discharge, irregular cycle)			
Chronic or Recurrent Skin Problems? (Acne, Eczema, Etc.)			
Frequent Headaches			
Convulsions or Other Neurologic Problems			
Thyroid or Endocrine Problems			
Other Significant Problems			
Cancers			
Receiving Medical Care from a Specialist			
Taking Any Daily Medications, Vitamins, or Herbal Supplements			
Delayed or Missing Immunizations			
Recurrent Medical Problems (Ear Infections, Strep Throat, UTIs)			

PATIENT'S SOCIAL HISTORY

Social History	Comments
Behavioral or Mental Health Problems	
History of Child Abuse	
Use of tobacco, drugs, alcohol	
Animals/Pets in Household	

Patients Name: ____________________________ Patients DOB: _____/_____/______ **HEALTH HISTORY CONTINUED**

FAMILY MEDICAL HISTORY

Condition	YES	NO	Family Member	Comments
Comments				
Deafness				
Nasal Allergies				
Asthma				
Tuberculosis				
Heart Disease Prior to Age 50				
High Blood Pressure Prior to Age 50				
High Cholesterol				
Anemia				
Bleeding Disorders				
Liver Disease				
Kidney Disease				
Diabetes (Prior to Age 50)				
Bed-wetting (After 10 Years of Age)				
Epilepsy or Convulsions				
Alcohol Abuse				
Drug Abuse				
Mental Illness				
Mental Retardation				
Immune Problems, HIV, or AIDS				
Additional Pertinent Concerns				

PATIENT'S BIRTH HISTORY

Birth History	Comments
Baby's Gestational Age	__________weeks
Birth Weight	__________lbs. _________oz.
Birth Hospital	
Doctor who delivered child	
Vaginal or C-section?	
Breastfeeding, Formula Feeding, or Both?	

Please answer the following	YES	NO	Comments
Was Hepatitis B vaccine given in hospital?			
Was Hearing Screen passed in hospital?			
Did the child have jaundice?			

OTHER OCCUPANTS LIVING WITH CHILD:

Name: ______________________________ Age:____________ Relationship:___________________________

Name: ______________________________ Age:____________ Relationship:___________________________

Name: ______________________________ Age:____________ Relationship:___________________________

Name: ______________________________ Age:____________ Relationship:___________________________

NO SHOW POLICY

Your time is important to us and while we strive to provide quality care to all of our patients and families, we must also adhere to our practice polices. Please understand that your scheduled appointment time has been reserved especially for you. Late cancellations or missed appointments negatively impact our schedule.

We have an implemented No Show policy in Tuka Pediatrics.

It is required that **new patients** arrive 30 MINUTES prior to your child's scheduled appointment time for insurance and paperwork purposes. For any subsequent appointments, we ask that you arrive 15 minutes prior to your scheduled appointment time. As a courtesy to our providers, staff, and other patients, we ask that you call at least 24 hours in advance of your scheduled appointment time for cancellations. If unable to, please notify us as soon as possible. **If you arrive late for your appointment and we do not have availability, your appointment will need to be rescheduled.**

If you do not call to cancel your child's appointment, a "no show" will be documented in the child's chart.

Please initial next to each statement.

_______After the first "no show", you will be given a courtesy call to inform you of your missed appointment.

_______Any "no show" after the first “no show” will incur a fee of $25 . Your insurance will not cover this fee.

I certify that I have read, understood, and agree to the terms presented above.

Patient Name:____

Parent Name: ____

Parent Signature:____

Date:____

TUKA PEDIATRICS AGREEMENTS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have had the opportunity to review a copy of the Tuka Pediatrics Notice of privacy practices. I understand that I am responsible to read this Notice and notify Tuka Pediatrics, in writing, of any request for restrictions in the use or disclosure of my child's individually identifiable health information. I understand the notice included electronic access to my child's medical history. Tuka Pediatrics has the right to revise this Notice at anytime and will post the notice on the practice website. Tuka Pediatrics will provide me with a copy of its most recent Notice upon my request.

Patient name: ____

Date of Birth: ________/_________/_________________

Parent, Guardian or Legal Representative Signature:

____

Person(s) authorized to have access to child's records:

Name: ____

Relationship: ____

Name: ____

Relationship: ____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services (including laboratory) and procedures rendered at Tuka Pediatrics. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services.

Tuka Pediatrics may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Tuka Pediatrics in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Tuka Pediatrics. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

Settlements/financial responsibilities, such as divorce, must be resolved between parents. We do not get involved with these issues.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is my responsibility to provide Tuka Pediatrics with a copy of my child's **current insurance card.** If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify Tuka Pediatrics immediately upon any change in my insurance.**

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and course of treatment, the administration of all anesthetics, and any and all medication which in the judgment of my provider may be considered necessary or advisable for my child's diagnosis and/or treatment.

I understand additional charges ($35.00) are applied to my account for any returned checks used to pay on my account. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, and for other administrative expenses not covered by my insurance plan.

In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Tuka Pediatrics.

FORM FEE

For special forms to be completed, you will be charged $25.00 per form. Physical and shot record forms requested after the well-exam visit will incur a charge of $10.00 per set. This fee must be paid in full prior to receiving the completed forms. Tuka Pediatrics will not hold the liability of faxing or mailing any forms. Please give us 48-72 hours notice when requesting forms so that we have adequate time to prepare them.

***ALL INSURANCES WE ACCEPT ARE SUBJECT TO CHANGE WITHOUT NOTICE.**

ASSIGNEMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patients, directly to Tuka Pediatrics. I hereby authorize Tuka Pediatrics to release medical information necessary to obtain payment. I understand that I am financially responsibly for all charges not covered by my insurance plan.

BY SIGNING THIS AGREENMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDIITIONS.

Patient's Printed Name: ____

Patient's Date of Birth: ________/__________/_____________

Parent, Guardian or Legal Representative Signature: _________________________________ Date: ____________________