# New Patient Information Sheet
**Village Pediatrics, LLC**

Today's Date: ________________ Gender: ____________________

**Patient Information:** ______________________________________________ Date of Birth: ______________________________
Last First Middle
SS# ______________________________
Address: ____________________________________________________________ Home Phone: (____) ___________________
Street; Apt#
_____________________________________________________________________________________________________________
City State Zip

**Parent(s)/Guardian(s) Information:**

(1) _____________________________________________________________ Relationship to Patient: ______________________
Last First Middle SS#_______________________________________
Email Address: ____________________________________________________________________________________
Address: _______________________________________________________ Cell Phone: (____) _________________
Occupation: ___________________________________________________Work Phone: (____) _________________
Work Address: ___________________________________________________________________________________

(2) _____________________________________________________________ Relationship to Patient: ______________________
Last First Middle SS#_______________________________________
Email Address: ____________________________________________________________________________________
Address: _______________________________________________________ Cell Phone: (____) _________________
Occupation: ___________________________________________________Work Phone: (____) _________________
Work Address: ___________________________________________________________________________________

In case of Emergency, please provide a name of a friend or relative:

_____________________________________________ Phone: (____) _____________ Relationship to Patient: _______________
Last First

**Health Information:**

Primary Insurance
Company Name: _________________________
ID# _________________________
Group: _________________________
Address: _________________________
Subscriber's Name: ______________________
Subscriber's DOB: ______________________
Subscriber's SS# ________________________
Copay: _________________________

Secondary Insurance
Company Name: _________________________
ID# _________________________
Group: _________________________
Address: _________________________
Subscriber's Name: _______________________
Subscriber's DOB: ________________________
Subscriber's SS# _________________________
Copay: __________________________

Office Policy
I authorize Village Pediatrics, LLC to treat my child. I understand that payment is expected in full at time services are rendered by the person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, a non-covered service(s), co-pay, and/or deductibles will be collected at time of visit. Arrangements for anything other than full payments at time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services in full. I understand that I am financially responsible for any balance not covered by my insurance carrier, I have read and understand the office policy for payment and agree to the terms stated.

Parent/Guardian Signature: ___________________________________________ Date: ______________________________________

# **Village Pediatrics, LLC:** ***New Patient Questionnaire***

Date: _________________

***Patients Name:*** _______________________________________ ***DOB:*** _________________

*Newborn/Neonatal History: (Please Check/fill in appropriate information)*

Adopted: (Yes__/No__)
Any known history: (Yes__/No__) If so please fill in the following.

**Pregnancy:**

Normal (Yes__/No__) Number of week gestation____________________________
Complications: Premature Labor ___ Preeclampsia ___ Infection ___ Other ________________________________
Alcohol (Yes__/No__) Smoking (Yes__/No__) Substance use (Yes__/No__) __________________________
Medications/Vitamins _____________________________________________________________________

**Birth History:**

Home Birth (____) Birthing Center (____) Hospital (____)
Name of facility and Doctor/Midwife/Practitioner: _____________________________________________
Delivery Type: Normal Vaginal (____) Forceps (____) Suction (____) VBAC (____)
C-Section Routine/Scheduled (____) Emergency (____) Please Explain: _____________________
Birth Weight: __________ Discharge Weight: __________
Hepatitis B Vaccine given at birth (Yes__/No__) Vitamin K (Yes__/No__) Eye Ointment (Yes__/No__)
Blood Type: Mother _____ Baby _____ Coombs: Positive _____ Negative _____
Newborn Nursery (____) Neonatal Unit (____) Length of stay ____________________________________________
Breastfed (____) Formula: which kind _________________________________________________________
Feeding Problems _________________________________________________________________________
Jaundice/Hyperbilirubinemia (____) Phototherapy # day's ________________________________________
Respiratory: TNN (____) Pneumonia (____) Ventilator (____) CPAP (____) O2 (____)
Infection: Group B Strep (____) R/O Sepsis (____) Antibiotics (____) # of day's ______________________________
Anemia (____) Transfusions (____) Newborn Screening Performed (Yes__/No__)
Circumcision (Yes__/No__) Planning but not performed yet (____) Hearing Screening (Pass__/Fail __)
Other Important information: _______________________________________________________________

*Has your child had any of the following? (Please Check/fill in appropriate information)*

**ENT:** Ear Infections (____) Hearing Loss (Left____) (Right____) Other ear issues ______________________________
Throat Infections (____) Strep (____) other throat issues____________________________________________
Nose bleeds (____) Allergic Rhinitis (____) Chronic Sinus Infections (____) Sleep Apnea (____)
Other Nose Issues _________________________________________________________________________
**Cardiac:** Heart Defect (____) Type _______________ Heart Murmur (____) Type ____________________________
Arrhythmia (____) Other Heart/Cardiac Issues _________________________________________________________
**Respiratory:** RSV (____) Bronchitis/Bronchiolitis (____) Asthma (____) Cystic Fibrosis (____) Pneumothorax (____) Pneumonia (____)
Type _________________ Required Hospital Stay(Yes__/No__)
Other Respiratory Issues _______________________________________________________________________
**Gastrointestinal:** GERD (____) Constipation (____) Chronic Diarrhea (____) Other ___________________________
**Genitourinary:** Hernia (____) Hydrocele (____) Bedwetting (____) UTI (____)
VCUG/Ultrasound/Renal Scan (Yes__/No__) Results/Procedures ___________________________________________
**Dermatological:** Skin Infections (____) Eczema (____) Acne (____) Other__________________________________
**Allergies:** Medication (____) Environmental (____) Food (____) Specify________________________________________
**Endocrine:** Diabetes: (____) Type I (____) Type II (____) Age of Diagnosis ______________________________________
Hypothyroidism (____) Hyperthyroidism (____) Other______________________________________________________
**Hematology/Oncology:** Anemia (____), Bleeding Disorders (____) Type ___________________________________ Cancer (____)
Type______________________________ Other ___________________________________________
**Neurology/Psychology/Developmental:** Seizures (____) Type __________________ Low Tone (____)
Hyper Tone(____)OCD(____) Cerebral palsy (____) Autism(____) Asperger Syndrome(____) ADD/ADHD (____) Bipolar Disorder(____)Anxiety (____) Delayed(____) Speech/Language (____) Behavioral Issues (____)
Other ________________________________________________________________________________
**Genetic Disorders:** Specify __________________________________________________________________

(Over)

**Surgery:** (List dates/hospital/type)

________________________________________________________________________________________________
_____________________________________________________________________

**Hospitalizations:** (List dates/hospital/reason)

________________________________________________________________________________________________
_____________________________________________________________________

**Injuries/Fractures:** (Date/Treatment)

________________________________________________________________________________________________
_____________________________________________________________________

**Medications/Supplements:**
Past________________________________________________________________________________
Present ____________________________________________________________________________

**Immunizations:** Up to Date (Yes__/No__) Delayed (Yes__/No__) Religious Exempt (Yes__/No__)

**Education:** Grade _____ School _________________________ Performance _________________________________
Additional Assistance ______________________________ Sports/Activities _________________________________

**Pets:** (Yes__/No__) Type _____________________________________________________________________

**Does anyone in the Family smoke?** (Yes__/No__) Who? _________________________________________________
Inside or Outside? _________________________________________________________________________

**Social:** Parents: Married (____) Together (____) Separate (____) Divorced (____) Blended family (____)
Child (children) live with _____________________________________________________________________

**Family History:**
List significant history and whether or not relative is on maternal (M) or paternal (P) side.
Mother adopted (____) Father adopted (____)

Heart Attack (____) (____) Stroke (____)(____) High Blood Pressure (____) (____) High Cholesterol (____) (____) Aneurysm (____)(____) Blood Disorders (____)(____) Diabetes (____)(____) Type: Juvenile/ Adult
Obesity (____) (____) Alcoholism (____) (____) Other substance abuse (____) (____)
Mental Illness: specify (____) (____) Other problems: _____________________________________________

**List immediate family members, age and whether or not they have health issues:**

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________

**Any other information you would like to share?**

________________________________________________________________________________________________
_____________________________________________________________________

***I have had the opportunity to review the Notice of Privacy and have no other questions.***

Signature __________________________________________ Date ____________________________

Witness ___________________________________________ Date ____________________________

Village Pediatrics, LLC
319 West Town Place, Suite 1
St. Augustine, FL 32092
Tel: (904) 940-1577 Fax: (904) 940-1916

Palencia location -
290 Paseo Reyes Dr.
St. Augustine, FL 32095

# Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

**Appointments:**

1) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment we would appreciate 24 hour notice.
   **There is a charge of $25 for missed appointments.**
2) If you are late for your appointment (>15 minutes) we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time, however emergencies do occur, and such will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy (well child) visit. **Initial:** __________

**Insurance Plans:** *Please understand:*

1) It is your responsibility to keep us updated with your correct insurance information. **If the Insurance Company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) If we are your Primary Care Physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan in regards to covered services, participating laboratory, etc. For example:
   a. Not all plans cover annual healthy (well) physicals, sports physicals or hearing and vision screenings. If these are not covered, you will be responsible for payment.
   b. For children less than 2 years of age there is a limit as to the # of allowable well visits per year. If the # of visits is exceeded, your Insurance Company will not pay; therefore you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether or not preauthorization is required prior to a procedure and what services are covered.

**Initial:** __________

**Referrals:**

1) Advance notice is needed for all non-emergent referrals, typically 3-5 days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember we must approve referrals before they are issued. **Initial:** __________

(over)

**Financial Responsibility:**

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances.
2) **Co-payments** are due at the time of service. A **$10 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB). Your remittance is due within **10** business days of your receipt of the bill.
6) If previous arrangements have *not* been made with our finance office, any account balance outstanding greater than 28 days will be charged a **$10 re-bill** fee for each 28 day cycle. Any balance over 90 days will be forwarded to a collection agency.
7) For scheduled appointments, prior balances must be paid prior to the visit.
8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a copy of a personal credit card to remain on file.
9) We accept cash, checks, Visa and Master Card credit and debit.
10) A $25 fee will be charged for any checks returned for insufficient funds.

**Initial:** __________

**Forms:**

1) There is no charge for a blue and yellow form given at the time of your child's visit. This is considered part of the visit. **However**, should you lose your forms there is a $5 charge ($3 for one form) to replace them.
2) Any additional school, camp or sport forms are subject to a $5 per form fee. FMLA forms $25. Payment is due when the forms are dropped off. We require 3 day turnaround time. **Initial:** __________

**Transfer of records:**

1) If you transfer to another physician we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours notice.
2) A copy of your complete record is available for a $1 per page fee.
3) We provide records of your child for visits (including consults from specialists) rendered here at Village Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

**Initial:** __________

**Prescription refills:**

1) For monthly medication refills, we require 48 hours notice, during regular business hours. Please plan accordingly. **Initial:** __________

**I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.**

Patient Name(s) ______________________________________________

Responsible party member's name ______________________ relationship______________

Responsible party member's signature______________________ Date______________

*Upon Completion we will provide you with a copy for your records.*

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# Authorization to Release Medical Records

Patients Name: ____________________________________________________________
Date of Birth: ________________________ SS#: __________________________________
Address: ___________________________________________________________________
City: ________________________________State:______________Zip:________________
Telephone Number: ____________________ Date of Treatment: ______________________

I, the undersigned, hereby authorize: (your former Pediatrician)
Name: _____________________________ Location: ______________________________
Address: ___________________________________________________________________
City: ________________________________ State: _____________ Zip: _______________
Telephone: __________________________ Fax: ________________________________

**The specific information to be used or disclosed is as follows:**

Complete Health Record _______ Operative Reports __________ Pathology Reports _________
Laboratory Reports ________ Radiology Reports ___________ Cardiology Reports __________
Other Testing Results ______________ Emergency Room Discharge Summary______________

I understand that this authorization is voluntary. I can refuse to sign this authorization. I understand that I have the right to inspect and copy the information to be used or disclose is pursuant to this authorization. I understand that once this information is received by the authorized person or organization then may be subject to redisclosure and may no longer be protected by federal privacy laws.

**I hereby authorize the above use and disclosure.**

Signature of Parent or Legally Authorized representative: ______________________________

Date: ____________________

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# Permission to Treat

This is permission that in my absence:

Names:_____________________________________Relationship______________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

May seek, obtain and make any and all decisions for the emergency medical care of my child(ren),

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Parent signature___________________________________

Date: _____________________

Village Pediatrics, LLC

# Credit Card Authorization

I, _____________________________, hereby authorize Village Pediatrics, LLC, to charge my credit card the balance of payment due Village Pediatrics, LLC after receiving notice from my insurance company. The amount charged is not to exceed the amount due. I also understand that I am responsible for payment of services should credit card be declined for any reason.

Village Pediatrics, LLC will send a receipt of the charges along with an explanation of benefits. These documents are to be used should the insurance company audit any claims filed by Village Pediatrics, LLC.

Name(s) of patients_______________________________________________________________

Date of service_________________________________________________________________

Name of cardholder________________________________________________________________

Cardholder signature_______________________________________________________________

Credit card number________________________________________________________________

Expiration date_________________

Security number (3digit code on back of card)_____________

Should you decline to provide credit card information, payment in full is expected at the time of service.

Village Pediatrics, LLC (witness)____________________________________________________

Signature_______________________________________________________________________