Sun 'N Lake Medical Group
Internal & Pediatric Medicine

Child's Name:_____
First **Middle** **Last**

Child's Address:_____
Street City, State, Zlp

Today's Date: _____

Filling out this form

■ Answering these questions will help your doctor understand your child's health and how best to treat your child.

■ If you need help filing out this form:

• Bring this form with you to your appointment and a nurse will help you.

OR

• Call the clinic at 863-386-4711 before your appointment and someone can help you over the phone.

Bring to your appointment:

1. This **Child Health History Form** and any other important medical records.
2. A complete copy of the child's **Immunization (shot) records.**
3. The child's **insurance information.**
4. Any **medicines the child takes**
(Prescription, herbal, over-the-counter pills, liquids, and creams)

We look forward to working with you!

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General information:

What is the child's sex? ☐ Female ☐ Male

Child's Date of Birth_____ current age_____

Is your child adopted? ☐ No ☐ Yes If yes, at what age? _____

Who is filling out this form?

- ☐ Mother
- ☐ Father
- ☐ Guardian (please explain relationship to child)_____

The child's parents are:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated but not divorced
- ☐ Widowed
- ☐ Living together but not married
- ☐ Other (please explain) _____

Main adult contact for child	Other adult contact for child
Name:	Name:
Relationship to child: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____	Relationship to child: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____
Address: ☐ Same as child Street Address: _____ _____ City:_____ State:_____ Zip:_____	Address: ☐ Same as child Street Address: _____ _____ City:_____ State:_____ Zip:_____
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Social Security Number:	Social Security Number:

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Today's Health Problems:

1. List your child's **main health problems** (or reasons for visiting the clinic).
   - ☐ Routine checkup
   - ☐ Immunizations
   - ☐ A health problem (please specify) _____
   - ☐ Switching doctors (last doctor) _____

2. How well do you feel your child acts or behaves?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Medical History:

3. Has your child been a **patient in a hospital** (other than a few days after birth) ☐ YES ☐ NO

My child was in the hospital because:	When:

4. Is your child taking and **prescription medicines?**
   - ☐ No, my child does not take any medications
   - ☐ Yes – Please list the child's medicines below **OR** ☐ I brought my child's medicines

Name of medicine:	Dose:	How many pills or doses does your child take at			
		morning	noon	evening	bedtime
		morning	noon	evening	bedtime
		morning	noon	evening	bedtime
		morning	noon	evening	bedtime
		morning	noon	evening	bedtime

5. What **over-the-counter medicines** does your child take regularly?
   - ☐ Vitamins(please list):_____
   - ☐ Herbal medicines(please list):_____
   - ☐ Other(please list):_____
   - ☐ None, my child does not take any over-the-counter medicines

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6. Does your child have any **allergic reaction (bad effect)** from any of the following?

☐ Outside or Indoor allergies (ex. Grass, pollen, cats …) _____
☐ Food allergies (peanuts, milk, wheat…) _____
☐ Medicine or shots (please list below)
☐ No, my child has no allergies that I know of.

Medicine child is allergic to:	What happens when the child takes the medicine?

7. Has your child has any of the following **diseases**?

Measles	Yes	No	I Don't Know
Mumps	Yes	No	I Don't Know
Chicken Pox	Yes	No	I Don't Know
Whooping Cough	Yes	No	I Don't Know
Rubella	Yes	No	I Don't Know
Rheumatic Fever	Yes	No	I Don't Know
Scarlet Fever	Yes	No	I Don't Know

8. Please check any of the following **medical problems** that your child has **ever** had.

Ear infections	YES	NO
Nose problems	YES	NO
Eye problems	YES	NO
Hearing problems	YES	NO
Mouth or throat problems	YES	NO
Diarrhea (frequent and runny bowel movement/poop)	YES	NO
Constipation (problems having a bowel movement/poop)	YES	NO
Throwing up (vomiting)	YES	NO
Problems **peeing** (wetting the bed, pain with peeing)	YES	NO
Back problems (back pain or a crooked back)	YES	NO
Growing pains (bone or body pains due to growing)	YES	NO
Muscle and bone problems (weak muscles, pain in joints)	YES	NO
Skin problems (acne, flaking skin, rashes, hives)	YES	NO
Seizures (shaking fits)	YES	NO
ADD/ADHD (problems paying attention or sitting still)	YES	NO
Sleeping problems (falling or staying asleep)	YES	NO
Breathing problems (cough, asthma)	YES	NO
Warts	YES	NO
Jaundice (yellow skin)	YES	NO

9. Has your child received immunizations (shots) in the past?

☐ No (If no, go to question #10.)
☐ Yes
If yes, have you given this office a copy of the immunization (shots) records? ☐ Yes ☐ No

If not, please give us the name of the doctors' offices or clinics where your child has received these shots so we can get the records.
Doctor's office/clinic name: _____
Doctor's office/clinic phone number:_____

About Mom when Pregnant:

(The following questions are about the mother of the child during pregnancy and birth. If you do not know about the pregnancy of the mother, check here ☐ and go to question #17.)

10. What was the general health of the mother during pregnancy?
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unknown

11. Were any of the following used during pregnancy?
☐ Cigarettes
☐ Alcohol
☐ Illegal drugs (which ones? _____)
☐ Prescription drugs (which ones? _____)
☐ None of the above

12. Did the mother have any of the following conditions or problems during pregnancy?

☐ Preeclampsia (high blood pressure) ☐ Diabetes (sugar) ☐ Emotional stress
☐ Injury or serious illness ☐ Unexpected bleeding or spotting
☐ Other _____

13. Was the birth:
☐ On the due date
☐ Before the due date (by how much_____)
☐ After the due date (by how much_____)

14. Was the birth: ☐ Vaginal? ☐ C-Section (surgical cut in the tummy)?

15. Were any of the following used?
☐ Pain medicine during birth (epidural) ☐ Tool to help pull baby out (forceps or vacuum) ☐ None

16. Were there any problems during the birth? ☐ Yes ☐ No
If yes, please explain _____

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About the Child as a Baby:

17. Was/is the child breastfed? ☐ Yes ☐ No If yes, how long_____

18. In the first 2 months after birth, did the child have:
☐ Jaundice (yellow skin)
☐ Colic (upset stomach, crying)
☐ Breathing problems
☐ Other_____

19. At what age did the child begin to crawl?_____
20. At what age did the child begin to sit up? _____
21. At what age did the child begin to walk? _____
22. At what age did the child get his/her first tooth? _____
23. At what age did the child began to say words (mama, dada)? _____

24. How would you rate your child's health in his or her first year of life?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

In School and at Home:

25. Does the child go to **school or daycare**? ☐ Yes ☐ No if yes, what is its name? _____

26. If your child goes to school or daycare, describe **how your child acts** in school or daycare. (check all that apply)
☐ Nervous, worried
☐ Hyper, restless, can't sit still
☐ Pushy, bullies other
☐ Relaxed, calm
☐ Social, friendly
☐ Shy, withdrawn, keeps to self
☐ Gets angry easily
☐ Scared
☐ Moody
☐ Happy

27. How are your child's **grades** in school? ☐ Excellent ☐ OK ☐ Poor ☐ Does not go to school

28. About how much exercise does your child get every day?
☐ Less than 30 minutes ☐ 30 minutes to 1 hour ☐ Over 1 hour

29. About how many hours of TV does your child watch every day?
☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

30. About how many hours is your child on a computer every day?
☐ Less than 1 hour ☐ 1-3 hours ☐ More than 3 hours ☐ Does not have a computer

31. About how many hours does your child spend outside every day?
☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

32. About how many hours are spent reading with your child every day?
☐ Less than 15 minutes ☐ 15-30 minutes ☐ 30 minutes to1 hour ☐ More than 1 hour

33. Does your child wear a helmet when riding a bike, roller blading, skate boarding, etc.?
☐ Yes ☐ No ☐ Does not do activities like that

34. Does your child get buckled in a car seat or wear a seat belt when riding in a car? ☐ Yes ☐ No

35. Do you have guns in the home? Yes ☐ No ☐ If yes, are they locked up? ☐ Yes ☐ No

36. What activities is your child involved in:
☐ Riding bike ☐ T-ball/baseball ☐ Dance/movement ☐ Skate boarding
☐ Karate ☐ Video games ☐ Girl Scouts/Boy Scouts ☐ Soccer
☐ Playing a musical instrument ☐ Reading
☐ Playing with friends
☐ Other team sports/Activities_____
☐ Too young to be involved in activities

Social History:

37. **Race** of the child (select multiple if they apply):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Pacific Islander ☐ Caucasian/White
☐ Hispanic ☐ More than once race ☐ Refuse to report
☐ Other _____

38. **Ethnicity** of the child: ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____

39. The child's **Country of Origin** if other than the United States _____

40. Preferred **Languag**e of the parent: ☐ English ☐ Spanish ☐ Other: _____

41. Preferred **Languag**e of the child : ☐ English ☐ Spanish ☐ Other: _____

42. Do you have any beliefs or practices from your religion, culture, or otherwise that your doctor should know? For example:
☐ I do not accept blood/blood products because of personal or religious beliefs.
☐ I do not use birth control because of personal or religious beliefs.
☐ I fast (go without food) for periods of time for personal or religious reasons.
☐ I do not eat meat ☐ I do not eat anything that comes from an animal.
☐ Other special diets or eating habits. (Please describe.)_____
☐ I use traditional medicines or treatments, such as acupuncture or herbs.
☐ Other beliefs_____
☐ No, I have no specific beliefs or practices that change the course of my health care

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Family:

43. Check all the people that the **child lives with**:
- ☐ Mother
- ☐ Father
- ☐ Brothers (how many?) _____
- ☐ Sisters (how many?) _____
- ☐ Other family members (list _____)
- ☐ Friends or other people (list _____)

Animals: ☐ Dogs (how many? _____) ☐ Cats (how many? _____)
☐ Other animals (list _____)

44. What medical problems do people in the child's family have?

Family Member	Medical Problems
Mother:	☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer ☐ High Blood Pressure ☐ Diabetes (sugar) ☐ Heart Problems Other: _____
Father:	☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer ☐ High Blood Pressure ☐ Diabetes (sugar) ☐ Heart Problems Other: _____
Sister:	☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer ☐ High Blood Pressure ☐ Diabetes (sugar) ☐ Heart Problems Other: _____
Brothers:	☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer ☐ High Blood Pressure ☐ Diabetes (sugar) ☐ Heart Problems Other: _____

Names of other children at this practice:

_____ _____

_____ _____

_____ _____

_____ _____

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Consent to Treat Form

1. I _____ (parent/guardian/patient) give permission for Sun 'N Lake Medical Group to give me medical treatment.
2. I allow Sun 'N Lake Medical Group to file for insurance benefits to pay for the care I receive.
   I understand that:
   - Sun 'N Lake Medical Group will have to send my medical record information to my insurance company
   - I must pay my share of the costs
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my provider.

Patient's Signature_____ Date_____

Parent or Guardian Signature _____ Date_____
(for children under 18)

_____ _____
Print name

HIPPA- CONSENT TO DISCLOSE HEALTH INFORMATION
FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

Consent to disclose my general health information:

By my signature below, I hereby authorize Sun 'N Lake Medical Group to disclose my medical information so that the practice may treat me, seek payment from third parties for such treatment and generally carry on the practice's health care operations (e.g., quality assurance). I also authorize Sun 'N Lake Medical Group to disclose my medical information to insurers and providers outside of the practice when necessary so that these providers may treat me; seek payment for that treatment, and for the purpose of their health care operations.

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside of the practice for the purpose of obtaining treatment for me, payment for the treatment proved to me, and so that these entities can carry out their health care operations:

- Information about HIV/AIDS status, venereal diseases
- Information about genetic testing
- Information related to confidential communications with a psychotherapist, psychiatrist, psychologist, social worker, mental health professional, or human services professional
- Information about diagnosis and treatment for substance abuse (alcohol or drug)
- Mammography results
- Information about family planning services including abortion consent forms
- If I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- Information about treatment with controlled substances

Note to patient: please strike any of the above –listed bullet points, to the extent you do not want the information disclosed.

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

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Permission to Bring/HIPPA

I, _____ the parent/legal guardian of _____, give the following person(s) permission to seek medical care for the above mentioned child in my absence. This is to be effective on date signed and to remain in effect until further notice is given.

The listed person (s) should also consider as **"emergency contacts"** in the event that you (the parent/legal guardian) are unable to be reached.

If we are allowed to discuss your child's medical condition with any person listed on the permission to bring you must mark the box.

May we phone, email, or send a text to you to confirm appointments? **YES NO**
May we leave a message on your answering machine at home or on your cell phone? **YES NO**

Name (Nombre)	Relationship to Patient (Relación con el paciente)	Phone Number (Numbero De Telefono)	Allowed to discuss HIPPA infomation Yes/No

Signature of parent (Firma del padre/guardián legal): _____

Date (Fecha): _____

FOR OFFICE USE ONLY

Witness (Testigo): _____

Identification verified (Identificación verificada): _____**Yes (Si)** _____**No**

Employee Initals (Iniciales del empleado): _____

Sun 'N Lake Medical Group
Internal & Pediatric Medicine

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, and Discover.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor- in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the copayment at the time of service. We will collect the copayment when you arrive for your appointment.
- If you have insurance coverage with a plan with whom we do not have a prior agreement, we will prepare and sent the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- All health plans are not the same and don not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.
- I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient/Parent/Guardian **Date**

Name of the Patient **Date of Birth**

Sun 'N Lake Medical Group
Internal & Pediatric Medicine

Medical Records Request

Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: _____

(City, State Zip) _____ **Phone #:** _____

For Record Release or copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.

This authorization permits:

_____ To use or disclose to **Sun 'N Lake Medical Group Pediatrics**
(Provider's Name)

_____ 4958 Sun 'N Lake Blvd Suite B
(Street Address)

_____ Sebring, FL 33872
(City, State, Zip)

_____ **Phone: (863) 386-4711 Fax: (863)3864301**
(Phone Number)

Information to be released/copied:
( ) All pertinent medical records including immunizations and lab tests
( ) Day sheets- Dates: _____ ( ) Lab Information- Dates: _____
( ) Other: _____

Information to be excluded/not released:
( ) Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV Testing
( ) Sexual Assault/Victimization records ( ) other: _____
Be sure to review any restrictions prior to copying/releasing

Reason for Record Release or Copy: _____
_____
(Please see below, charges could apply.)

For patient or Guardian Inspection/Copy Requests: ( ) Check Here
I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: $1.00 per page for the first 25 pages, then $0.25 for each page thereafter.

_____ _____
(Parent/Legal Guardian Signature) **(Date)**

_____
(Parent/Legal Guardian Name Printed)

*Inspection requests are valid on the date of signature only
*Release/Copy requests expire 30 days from signature date

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentially is protected by law. Any further disclosure is strictly prohibited unless the patient/guardian provides specific written consent from subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).

For Internal Purposes Only: Name and Title of Person Releasing Records: _____
Method of transfer: ( ) Mailed on: _____ **( ) Certified? (Certification #)** _____
( ) Picked up by: _____**/ (Date)** _____ **Form of ID:** _____
( ) Faxed: _____**/ (Date)** _____**Verification of ID Performed: ( ) Yes ( ) No**