LONGWOOD PEDIATRICS
1400 W SR 434, # 1010
LONGWOOD FL 32750

NEW PATIENT INFORMATION

Child's Last Name, First Name	Birth Date	☐ Male ☐ Female	SSN# Telephone #

Street Address	Apt #	City	State	Zip Code

Language	Race	Ethnicity
☐ English ☐ Spanish	☐ Asian ☐ African American ☐ White ☐ Pacific Islander	☐ Hispanic ☐ Non-Hispanic

PARENTS / GUARDIAN INFORMATION

Mother's Name	Birth Date	SSN#	Cell:	Email:

Father's Name	Birth Date	SSN#	Cell:	Email:

Consent to enroll in online patient portal (please circle one) Mother / Father

Consent to receive text messages for Appointment Reminders (please circle one) Mother / Father

GUARANTOR'S INFORMATION

Insurance Name	ID #	Group #

Guarantor's Name

Guarantor's Relationship to Child

☐ Self ☐ Mother ☐ Father ☐ Other _____

Who if anyone other than parent or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in Longwood Pediatrics LLC without your presence and making medical decisions for his or her treatment.

Name	Relationship
Name	Relationship
Name	Relationship

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Allergies Y / N
Medications
Food

Current Medications Y / N			
Name	Dosage	Frequency	Started on

Pharmacy (for transmitting electronic prescriptions)
☐ CVS ☐ Walgreens ☐ Publix ☐ Target ☐ Wal - Mart ☐ Other:
Address:
Phone Number:

Family History: First Degree relatives have no current problems or disability Y / N

If Yes, then please mark X in the boxes below to all that apply

Diagnosis	Siblings	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Thyroid disease							
Heart disease							
High BP							
Cancer (type)							
Diabetes							
Depression							
ADHD							
Learning disability							

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Social History (Please circle below)	
Is child living with Mother / Father/ Grand parents / Foster parents (please circle one)	
Siblings Y / N	How many ?
Passive smoke exposure Y / N	Pet's at home Y / N
Can child swim Y / N	Care giver Y / N
Smoke detectors in home Y / N	Seat belt use Y / N
Daycare Y / N	School Grade _____
Smoking Y / N (if >13 years of age)	Sexually active Y / N (if > 15 years of age)

Birth History	
Prenatal History	
Birth Hospital	
Birth Weight	
Type of Delivery (circle one)	Vaginal Delivery / C-Section
Gestational Age	
Medical Problems after delivery	

Past Medical History - Has your child ever had any of the following? (check as many as apply)	
☐ ADHD ☐ Asthma ☐ Allergies ☐ Autism ☐ Eczema ☐ Bronchiolitis ☐ Pneumonia ☐ Multiple ear infections	☐ Developmental delay ☐ Cerebral palsy ☐ Seizure disorder ☐ Thyroid disease ☐ Learning disability ☐ Reflux disease ☐ Headaches / Migraines ☐ Other _____

Past Surgical History (check as many as apply)	
☐ Tonsils Removed ☐ Adenoids Removed ☐ Inguinal Hernia Repair ☐ Appendicectomy	☐ Ear Tube Placement ☐ Heart Surgery ☐ Broken Bone ☐ Other _____

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Consent and Authorizations

Your Signature Will Serve for All of the Following:

Consent: I hereby give consent to Longwood Pediatrics LLC to provide necessary treatments discussed. I have received a copy of the Privacy Policy of Longwood Pediatrics and authorize use/disclosure of information to coordinate and/or manage my child's healthcare and any related services, receive payment for services and perform general healthcare operations. Longwood Pediatrics may contact me at my primary phone number or e-mail or text me on my cell number I have provided. It may If I am not available Longwood Pediatrics may leave a message on voice mail in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory and radiology results among others as per the Privacy Policy. Longwood Pediatrics may mail to my home, or other alternate address I have provided, any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, school immunization and or physical forms; all correspondence will be marked "Personal and Confidential".

Medical Release: I authorize any holder of medical or other documentation about my child to release to Longwood Pediatrics independent laboratories and insurance carriers any information needed for claims processing and payments. I permit a copy of this authorization to be used in place of the original.

Insurance Authorization: I authorize payment of medical benefits directly to the Longwood Pediatrics and/or the attending physician for services rendered.

Financial Responsibility: I have received a copy of Longwood Pediatrics Financial Policy and agree to abide by the terms set forth. I acknowledge that I am ultimately responsible for all charges incurred by my child(ren). It is my responsibility to provide the office with all necessary information to file insurance claims, and to notify the office of changes in coverage prior to any visits. I understand it is my responsibility to know my insurance coverage and benefits, including contracted laboratories/ hospitals where my child may receive care. I understand all co-pays, patient percentages and deductibles are due at the time services are rendered. I will be responsible for any charges not covered by my insurance policy.

Signature _____ Date:_____

Print Name _____Relationship:_____

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Records Release Authorization

Parent / Legal Guardian Name:	
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth

The Parent/Legal Guardian authorizes and requests LONGWOOD PEDIATRICS (check one):

□ Release to_____

□ Obtain from_____

Please release following medical information (check one)

□ All medical records

□ Immunization records and last physical exam notes

The purpose of releasing this information:

□ Changing Insurance □ Moving □ Other

My signature below indicates that I understand what information will be released and the need for that information. I further understand that the information to be released may include information regarding drug and alcohol abuse or AIDS/HIV. In addition, information related to drug and alcohol abuse in my child's records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2.

_____
Parent / Legal Guardian Signature

_____
Relationship

_____
Date