A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA
Dr Rupal Desai MD, Dr Reginald Sampang MD
Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP
4804 Rowan Road
New Port Richey, FL 34653
Phone (727) 375-5242
Fax (727) 375-5198
www.atozkidz.com

Patient Name: ____ **D.O.B:** ______/______/_______

Age: ____ **Sex:** _____ **Patient SS#:** ____________________ **E-Mail Address:** _________________________

Home Address: ____________________________________ **City:** ______________________ **State:** ______

Zip Code: __________ **Telephone #: (home):** ___________________ **(Cell):** _________________________

Father's Name: __________________________________ **SS#:** _____________________________________

Place of Employment: ___________________________ **Phone#:** __________________________________

Mother's Name: ______________________**Maiden Name:** _________________ **SS#:** __________________

Place of Employment: ___________________________ **Phone#:** __________________________________

Emergency contact #: _______________________ **Name:** _________________ **Relationship:** __________

Pharmacy Name: _____________ **Phone#:** ____________________ **Location:** _______________________

Other Children:

Name: ____ **D.O.B:** ___/_____/______ **Age:** ______

Name: ____ **D.O.B:** ___/_____/______ **Age:** ______

Name: ____ **D.O.B:** ___/_____/______ **Age:** ______

Please List Any Other Information You Feel Would Be Helpful To Us:

____

Please List Anyone In Which You Authorize To Make Medical Decisions And To Bring Your Child To Our Office In The Event That You Are Unavailable:

Name: _________________________ **Phone#:** ____________________ **Relationship:** _________________

Name: _________________________ **Phone#:** ____________________ **Relationship:** _________________

A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA
Dr Rupal Desai MD, Dr Reginald Sampang MD
Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP
4804 Rowan Road
New Port Richey, FL 34653
Phone (727) 375-5242
Fax (727) 375-5198
www.atozkidz.com

Insurance Information

Responsible Party Name: ________________________________ **D.O.B:** ________________

Relationship to Patient: _______________________ **Insured's SS#:** ____________________

Insurance Company Name: ____

Insurance I.D Number: ______________________________ **Group#:** ___________________

Insurance Address: ______________________ **City:** _____________________ **Zip:** _______

Insured's Place of Employment: ____

Please Read Carefully

I acknowledge full responsibility for the payment of the services rendered to me, and agree to pay for them in full at the time of service. (Co-payments & Deductibles are due at the time of service. Co-payments must be paid before seeing one of our providers.)

I understand and agree that health insurance policies are an arrangement between an Insurance Carrier and Myself. If a claim is denied because you have not provided correct information, the charges will be transferred to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, immunizations, and other procedures. I understand and agree it is my responsibility to pay any deductible amount, coinsurance, or any other deductible amount, or any other balance not paid for by my insurance.

When charges are filed with your insurance carrier and assignment of insurance benefits is accepted by our office, if the fees are not paid by the insurance company within 60 days, all fees become the patient's responsibility. Patient balances are due from you upon receipt of the statement. A $25.00 per month late charge is assessed on all delinquent patient balances. There is also a fee of $30.00 for any returned checks.

A photocopy of this signature is as valid as an original. I also authorize the physician to release all information necessary to secure payment.

Insured's Signature: ____ **Date:** __________________

A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA
Dr Rupal Desai MD, Dr Reginald Sampang MD
Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP
4804 Rowan Road
New Port Richey, FL 34653
Phone (727) 375-5242
Fax (727) 375-5198
www.atozkidz.com

Request for Limitations and Restrictions of Protected Health Information

Please Note: The Practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name: _________________________________ D.O.B: ____/____/______

Type of Protected Health Information to be restricted, Meaning: (what information would you like for us not to give to anyone.) Unless it is being requested by a specialist, hospital, law enforcement, court ordered, etc. (With the proper medical request form.) Please check all that apply.

____ Home Phone#

____ Home Address

____ E-Mail Address

____ Occupation

____Name of Employer

____ Visit Notes

____ Hospital Notes

____ Patient History

____ Office Address

____ Office Phone#

____ Spouse's Name

____ Spouse's Office Phone #

____ Other

____ Prescription Information

How would you like your Protected Health Information restricted?

____

____

Signature of Parent/Guardian: _________________________________Today's Date: _______________

A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA

Dr Rupal Desai MD, Dr Reginald Sampang MD

Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP

4804 Rowan Road

New Port Richey, FL 34653

Phone (727) 375-5242

Fax (727) 375-5198

www.atozkidz.com

Patient Consent For Use And Disclosure

Of Protected Health Information (PHI)

With my consent, A to Z Pediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to A to Z Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. A to Z Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to A to Z Pediatrics Privacy Officer at 4804 Rowan Rd, New Port Richey, FL 34653.

With my consent, A to Z Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information and may call pertaining to my clinical care, including laboratory results among others.

With my consent, A to Z Pediatrics may mail to my home or other designation location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that A to Z Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my personal restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to A to Z Pediatrics use and discloser of my PHI to carry out TPO, and that I have received the notice of privacy practice form from A to Z Pediatrics. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do sign this consent, A to Z Pediatrics may decline to provide treatment to me.

Signature or Parent/Legal Guardian: ___________________________________Today's Date: ________

A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA

Dr Rupal Desai MD, Dr Reginald Sampang MD

Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP

4804 Rowan Road

New Port Richey, FL 34653

Phone (727) 375-5242

Fax (727) 375-5198

www.atozkidz.com

Authorization For Treatment

Patient Name: ___________________________ D.O.B: ____/____/______ SS#: _____________________

I hereby request and give permission for the physicians of A to Z Pediatrics to provide such medical examination and treatment as they deem best for the child's physical or mental welfare.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physician office any insurance benefits due for services on behalf of the patient and I hereby assign to the physician's office all my rights to receive payment from my insurer and third parties for services rendered by the physician's office. I understand I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/father, referring physician, other physician's involved in the care of my child, and my insurance company (ies).

I, ____ parent or legal guardian of the above patient gives permission to A to Z Pediatrics to seek medical treatment for my child.

Signature: ____Today's Date: ________________________

A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA
Dr Rupal Desai MD,   Dr Reginald Sampang MD
Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP
4804 Rowan Road
New Port Richey, FL 34653
Phone (727) 375-5242
Fax (727) 375-5198
www.atozkidz.com

Five (5) BUSINESS DAY TURN-AROUND TIME

Dear Parents/Guardians: **(PLEASE READ CAREFULLY)**

We receive many phone calls from our valued patients for medication refills, referral requests, and other documents. Due to the high demand of these requests, we are asking that you contact the office five (5) business days in advance of any medication refills, referrals, or any other documentation that needs to be completed. This will allow our staff and doctors to spend more quality time with our patients instead of on the phone. In most cases, requests will be honored before this time.

Medication Refills: **Call us when you see you only have five days' worth medication left in each bottle. We will need to know the name of the medication. How you take it, the pharmacy name and telephone number, and a phone number to get back in touch with you.**

Referral Request: **Let us know the specialist you are going to see and the appointment day & time.**

Medical Forms/Letters: **Give the doctor ample time to review and answer any questions that each form and/or letter is asking. The doctors do not want to rush and put down incorrect information that could hold up your claim, sick leave, or personal grievance.**

SHOT RECORDS AND/OR PHYSICAL FORMS INCLUDED

****** We are more than happy to complete forms for sports, camp, etc. The charge is $10.00 for most forms (less than 2 pages) after 2 pages the charge will increase. ******

Thank you for taking the time and understanding of our busy staff members and doctors. Without you "The valued patient" There would be no "US".

Signature: ____Today's Date: _________________

A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA
Dr Rupal Desai MD, Dr Reginald Sampang MD
Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP
4804 Rowan Road
New Port Richey, FL 34653
Phone (727) 375-5242
Fax (727) 375-5198
www.atozkidz.com

Physical Exam Disclaimer

Patient Last Name: ____

Patient First Name: ____

Patient Date of Birth: ____

Dear Parent/Guardian:

Pre-participation Physical Exams cannot guarantee or accurately predict that your child is risk free. It is well known and understood that certain sports produce injuries and that some cardiac anomalies may present even with "normal" results from a routine screening test. Therefore, normal results from routine screening tests should not be interpreted as indicating that he/she is free from risk or that all potential cardiac anomalies have been ruled out.

I have read and agree with the above statement.

Signature: ____ Today's Date: ____________

A to Z Pediatrics

Your Child's Patient Centered Medical Home

Dr Haravu Lokesh MD MBA

Dr Rupal Desai MD, Dr Reginald Sampang MD

Tarah Savino MMS P.A-C, Carmela Jones ARNP-CPNP

4804 Rowan Road

New Port Richey, FL 34653

Phone (727) 375-5242

Fax (727) 375-5198

www.atozkidz.com

Authorization to Release Patient Medical Information

Records to be released from:

Previous Doctor or Facility: _______________________

Phone#: _____________________________________

Fax#: _______________________________________

Records to be released for:

Child's Name: ____________________ Date of Birth: ____/___/_____

I hereby authorize and request you to release any and all medical records and other pertinent patient information, including the complete history, physical records, laboratory, x-rays, and/or any treatment or examination rendered to

A to Z Pediatrics

For the purpose of diagnosis, care and treatment. You may refuse to sign this consent. This consent may be revoked at any time upon written notice, except to the extent that any person or organization has already taken action in release thereon. Information used or disclosed pursuant to this information may be subject to re-disclosure by the recipient and no longer protected.

_____________________________________ _________________________________

Name (please print) of Parent/Guardian Phone Number

_____________________________________ _____________________ ____________

Signature of Parent/Guardian Relationship to Patient Date

Pediatric Patient Information

Patient Information

Name: ____ Date of Birth: _____________________

Phone Number: ___________________________ Cell Number: ______________________________

Allergies: ____

Parent/Guardian Name: ________________________________Relationship to patient:___________________________

Parent/Guardian Name: ________________________________Relationship to patient: ___________________________

Is child adopted ◯ Yes ◯ No Interpreter needed ◯ Yes ◯ No

Prenatal History (0 to 6 months)

Mode of delivery:◯ Vaginal ◯ Primary C/S- Labored ◯ Vacuum◯ Primary C/S- No Labor ◯Forceps ◯ Repeated C/S

Birth Weight: _____________________________ Gestation: _________________________________

Complications with Pregnancy/ Delivery: ____

Newborn Metabolic Screen results: ◯ Pass ◯ Fail

Hearing screen results pass: ◯ Pass ◯ Fail ◯ Referred.

PAST MEDICAL HISTORY

None ....◯ Yes ◯No
Premature birth.............◯ Yes ◯No
Asthma............................◯ Yes ◯No
R.S.V. ....◯ Yes ◯No
Bronchiolitis....................◯ Yes ◯No
Allegic rhinitis.................◯ Yes ◯No
Hepatitis..........................◯ Yes ◯No
Heart defects/ heart disease..............◯ Yes ◯No
Seizures...........................◯ Yes ◯No
Previous reaction to immunizations........◯ Yes ◯No
Diabetes...........................◯ Yes ◯No
Recurrent ear infections............................◯ Yes ◯No
Bladder infections.......................................◯ Yes ◯No
Drug-resistant organisms (MRSA/VRE).....◯ Yes ◯No
HIV/AIDS...◯ Yes ◯No
Menstrual problems.................................◯ Yes ◯No
ADHD...◯ Yes ◯No
Mental Illness..◯ Yes ◯No
Behavioral/Learning problems.................◯Yes ◯No
Acne...◯ Yes ◯No
Are immunizations on schedule................◯ Yes ◯No
Eczema...◯ Yes ◯No
Hospitalizations..◯ Yes ◯No

____
____
____
____

____
____

Other health problems........................◯ Yes ◯No

____
____

Family History

		Relationship to patient	Age Diagnosed
Unknown	◯ Yes ◯No		
Aneurysms	◯ Yes ◯No		
Asthma	◯ Yes ◯No		
Bleeding tendencies	◯ Yes ◯No.		
Stroke	◯ Yes ◯No		
Pulmonary embolism	◯ Yes ◯No		
Heart problems	◯ Yes ◯No		
High cholesterol	◯ Yes ◯No		
High blood pressure	◯ Yes ◯No		
Seizures	◯ Yes ◯No		
Cancer	◯ Yes ◯No		
Diabetes	◯ Yes ◯No		
Mental illness	◯ Yes ◯No		
S.I.D.S	◯ Yes ◯No		
Birth defects	◯ Yes ◯No		
Genetic condition	◯ Yes ◯No		
Drug abuse	◯ Yes ◯No		
Alcohol dependency	◯ Yes ◯No.		
HIV/AIDS	◯ Yes ◯No		
Thyroid disease	◯ Yes ◯No		
Tuberculosis	◯ Yes ◯No		
Other health problems	◯ Yes ◯No		

Is child father deceased……………◯ Yes ◯No Cause of death: ____________________________________ Age: __________

Is child's mother deceased……….◯ Yes ◯No Cause of death: ____________________________________ Age: __________

Surgical History

None…………………………………◯ Yes ◯No

Appendoctomey……………….◯ Yes ◯No

Tonsilectomy…………………….◯ Yes ◯No

Adenoidectomy…………………◯ Yes ◯No

Ear tube placement………….◯ Yes ◯No

Other surgical procedures…◯ Yes ◯No

Social History

Who does the child lives with __________________________ total number of siblings: ____________

	Sibling's name	Relationship to patient	Age
1.			
2.			
3.			
4.			
5.			
6.			

Day care provider: ◯ Home day care ◯ Day care provider ◯ relative or friend ◯ none

Religious or cultural practices we need to know to better serve child's needs… ◯ Yes ◯No

Health Risk Profile

Latex Allergy Risk:

Allergic to latex…………………………◯ Yes ◯No

Reaction to medical procedure……◯ Yes ◯No ____

Reaction to dental procedure……..◯ Yes ◯No ____

Allergic to bananas…………………….◯ Yes ◯No

Allergic to kiwi…………………………….◯ Yes ◯No

Allergic to avocado……………………..◯ Yes ◯No

Allergic to chestnuts or any nuts…◯ Yes ◯No ____

Smoking Status:

Former smoker…………………………… ◯ Yes ◯No
Current every day smoker………… ◯ Yes ◯No
Current some day smoker…………. ◯ Yes ◯No
Smoker current status unknown…. ◯ Yes ◯No
Exposed to second hand smoke….. ◯ Yes ◯No (If ''yes,'' who and where?) ________________________________
Other tobacco use………………………. ◯ Yes ◯No ____
Alcohol use…………………………………◯ Yes ◯No
Recreational drug use……………………◯ Yes ◯No
Caffeine use…………………………………◯ Yes ◯No

Pediatric Health Risk Prevention:

Bike helmet use……………………………………………………………. ◯ Yes ◯No
Car seat/booster seat use……………………………………………… ◯ Yes ◯No
Seatbelt use…………………………………………………………………… ◯ Yes ◯No
Smoke detectors in home………………………………………………. ◯ Yes ◯No
Carbon monoxide detectors in home…………………………….. ◯ Yes ◯No

Pediatric Health risk Hazards:

Lead exposure………………………………………………………………… ◯ Yes ◯No
Guns in home…………………………………………………………………. ◯ Yes ◯No
Domestic violence …………………………………………………………… ◯ Yes ◯No
Alcohol use in home…………………………………………………………. ◯ Yes ◯No
Dental visit during past year……………………………………………… ◯ Yes ◯No
Do you feel safe at home…………………………………………………… ◯ Yes ◯No
Is someone threating you…………………………………………………… ◯ Yes ◯No
Do you want to discuss abuse……………………………………………. ◯ Yes ◯No