SHUKLA PEDIATRICS REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Sex: _____

Date of Birth: _____ Phone# _____ Phone# _____

Address: _____

PARENT/GUARDIAN INFORMATION

Fathers Name**:** _____ Date of Birth: _____

Occupation: _____

Mothers Name: _____ Date of Birth: _____

Occupation: _____

Legal Guardians Name: _____ Date of Birth: _____

Guardianship Realtion: _____

Occupation: _____

METHOD OF PAYMENT: _____

- I authorize Shukla Pediatrics and or my health insurance provider to release any information required to process my claims, I understand all self-pay payments are due at time of visit. I understand that I'm financially responsible for all co-payments and any charges not covered by my insurance.

AUTHORIZATION OF TREATMENT

I give permission to the persons named below to bring my child to their appointment in the case that I can not be present. I give permission to discuss my child's medical conditions, past and present and give consent for any treatments deemed necessary. If anything changes, I'm responsible to notify the facility in writing. I understand that the person bringing my child must show proper identification.

Authorized Person Name: _____ Patient Relation: _____

Authorized Person Name _____ Patient Relation: _____

Authorized Person Name: _____ Patient Relation: _____

SOCIAL HISTORY

Circle option below that applies: (patient resides with)

Mother/ Father/ Guardian

Pets: _____ Exposure to Tobacco: YES/NO

Siblings:

1. _____ Date of Birth: _____ Sex: _____
2. _____ Date of Birth: _____ Sex: _____
3. _____ Date of Birth: _____ Sex: _____
4. _____ Date of Birth: _____ Sex: _____

MEDICAL HISTROY

Allergies: _____ Respiatory Conditions: _____

Medications: _____ Eye Conditions: _____

Surgeries: _____ Heart Conditons: _____

Skin Condtions: _____ Urinary Conditons: _____

Headaches/ Migraines: _____ Diabetes/Thyroid Disease: _____

Other Medical Condtions: _____

FAMILY HISTORY

Asthma Who? _____ Hypertenion Who? _____

Cancer Who? _____ Hearing Loss Who? _____

Thyroid Who? _____ Allergies Who? _____

Heart Disease Who? _____ High Cholestrol Who? _____

Other Medical Conditions: _____

NEWBORN HISTORY

- Any complications during pregnancy or delivery? If yes, please explain below:

_____

_____

- Full Term/Premature (Please Circle One) Birth Weight: _____ Length: _____
- Feeding: (Please Circle One or Both if Applicable) Breastfeeding/ Formula
- Any smoking or subtance abuse during pregnancy? (circle one) YES or NO

OFFICE POLICY

New Patients: We will require parents state ID, Patients insurance card or present form of coverage, legal guardianship documents (if applicable) patients vaccination records and any medical records present day of new patient appointment.

Cancelation or Rescheduled Appointments: If you need to cancel or reschedule appointments, please allow 24 hours notice in advance. Three consecutive no shows are penalized by a fee of $20.00 and can result in being discharged from practice,this is patient responsibility.

Patient Responsibility: It is patient responsibility to keep up with recommended periodic general health exams, failing to do so may result is being discharged from practice. This includes vaccine refusal patients; we will always recommend vaccines but those who choose not to, must sign an in office waiver. If patient needs any forms to be filled out, please inform staff prior to the appointment (be aware that there is a charge for school sports forms to be completed and there maybe additonal charges for completion of other forms) All sections of all forms must be completed by the parent before the office can complete their portion. Please be aware it takes 72 hours for forms to be completed by our office staff. It is the responsibility of the parent/guardian to let Shukla Pediatrics know, when a patient is seen by an Urgent care or Emergency room as we may not always get the records from other facilities.

Release of Medical Records: New patients have the right to request a release of medical records form for the transfer-in of care, This form can only be completed by parent/guardian. For the transfer out of medical records this form must only be submitted via fax by the new providing facility under the request of the parent/gaurdian. Keep in mind these records only include records from this facility Shukla Peditraics, third party records are not included. Please allow a 72 hours process for this transfer out request. For the request of personal medical records, we require a medical release form to be completed and signed. If someone other than the guardian is being authorized to pick up medical records a notarized letter is required with proper identification, We do not email any personal records or school notes. There is a charge of a $1.00 per page for personal record release. Request for school physcials and or vaccination records should be done the day of visit, free of charge any other day records have an applied fee.***Cost for reproducing medical records are in accordance with the FL Administrative Register Rule 64B8-10.003 and F.S. 164.524©4.***

Appointment reminders and messaging

You will automatically be enrolled in Text / SMS reminders and messaging system

Patients Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____