

Parent or Guardian Information

Name: Mother/Guardian _____

Address: _____

Cell Phone Number: _____

Place of Work: _____

Work Phone: _____

Date of Birth: _____

Email: _____

Name: Father/Guardian _____

Address: _____

Cell Phone Number: _____

Place of Work: _____

Work Phone: _____

Date of Birth: _____

Email: _____

Insurance Information

Who is the insurance policyholder? **Mother / Father** (please circle)

Insurance Policy Number: _____

Emergency Information

Contact Person: _____

Address: _____

Phone Number: _____

Relationship to the patient: _____

Referral Information

Whom should we thank for your visit?

Name: _____



Patient Financial Responsibility and Medical Release

I, by signing below, understand that I am responsible for any balance not covered by my health insurance. Starfish Pediatrics will submit all payment claims to health insurers, but I understand that I am responsible for any balance not paid by the insurance within 120 days of the medical visit. If you fail to meet your obligation to the office, your account will be sent to a debt collection agency or an attorney. I will be responsible for all charges that may arise, including attorney fees, debt collection agency fees, credit bureau fees, and any legal expenses. For all of the foregoing, I authorize the release of any information related to the visit or to my examination day. I understand and sign below as acknowledgment.

Signature: _____ **Date:** _____

Relationship to the patient, if signed by another person: _____



Patient Information

DATE: _____

Child's Name: _____ Date of Birth: _____

Parents' Names: _____

Siblings' Names: _____

MALE _____ FEMALE _____ If twins, circle: **Twin A / Twin B**

Family Medical History

Circle all conditions that family members have had: siblings, parents, aunts/uncles, grandparents, and cousins. Please specify which ones and the relationship to your son / daughter, next to the condition.

Asthma	Hypertension	Anemia
Allergies	High Cholesterol	Clotting Disorders
Eczema (atopic dermatitis)	Heart Attacks	Reaction to Anesthesia
Cystic Fibrosis	Diabetes	Depression / Anxiety
Birth Defects	Kidney Problems	Substance Abuse
Seizures	Liver Problems	Cancer (specify type) _____
ADHD	Anemia	Other (specify) _____

Birth History (circle the options that apply)

Did the mother receive prenatal care? **No Yes**

Was your baby born between 37-42 weeks? If premature, how early? _____

Was the delivery vaginal or cesarean? If cesarean, why was it necessary? _____

Did the mother have any problems during pregnancy? **No Yes**

Herpes, gonorrhea, chlamydia, syphilis, HIV, urinary infection, other _____

Did the mother test positive for group B streptococcus (GBS) during this or a previous pregnancy? **No Yes**

* If yes, did she receive any antibiotics during delivery? **No Yes Don't know**

What was your baby's birth weight? _____ lbs. Mother's blood type _____

Did the baby have any problems in the newborn unit before being discharged? **No Yes**

Jaundice, low blood sugar, feeding problems, breathing problems, heart murmur, suspected infection, sepsis, pneumonia, other _____

Hospital Name _____ Length of hospital stay _____

Did the baby go to the NICU or newborn intensive care? **No Yes**

Was the baby at least 48 hours old when the newborn metabolic screening (phenylketonuria, PKU) was done? **No Yes**

Did the baby pass the hearing test? **No Yes**



Dependent Information

Child # 1

First Name: _____ Middle Name _____ Last Name _____

Male / Female (please circle)

Date of Birth: _____

Social Security Number: _____

Child's Primary Doctor: _____

Preferred language (please circle): English / Spanish

Race (please circle): American Indian or Alaska Native / White / Asian / Black or African American

Ethnicity (please circle): Hispanic or Latino / Not Hispanic or Latino

Child # 2

First Name: _____ Middle Name _____ Last Name _____

Male / Female (please circle)

Date of Birth: _____

Social Security Number: _____

Child's Primary Doctor: _____

Preferred language (please circle): English / Spanish

Race (please circle): American Indian or Alaska Native / White / Asian / Black or African American

Ethnicity (please circle): Hispanic or Latino / Not Hispanic or Latino

Child # 3

First Name: _____ Middle Name _____ Last Name _____

Male / Female (please circle)

Date of Birth: _____

Social Security Number: _____

Child's Primary Doctor: _____

Preferred language (please circle): English / Spanish

Race (please circle): American Indian or Alaska Native / White / Asian / Black or African American

Ethnicity (please circle): Hispanic or Latino / Not Hispanic or Latino

Child # 4

First Name: _____ Middle Name _____ Last Name _____

Male / Female (please circle)

Date of Birth: _____

Social Security Number: _____

Child's Primary Doctor: _____

Preferred language (please circle): English / Spanish

Race (please circle): American Indian or Alaska Native / White / Asian / Black or African American

Ethnicity (please circle): Hispanic or Latino / Not Hispanic or Latino



Lead Risk Assessment

(Check all that apply)

- ☐ The home or daycare was built before 1970 ☐ before 1950 ☐ has chipped or peeling paint.
- ☐ The child eats dirt, clay, or peeling paint.
- ☐ The child's friends, classmates, or neighbors have high lead levels.
- ☐ The parents' work is exposed to lead or anything similar.

TB Risk Assessment

(Check if your child has had close contact with adults who...)

- ☐ Are homeless or live in shelters.
- ☐ Live or work in prison.
- ☐ Live or work in nursing homes.
- ☐ Have TB, HIV, AIDS, or abuse drugs.
- ☐ Are immigrants from Central or South America, Haiti, Russia, Europe, India, or Southeast Asia.
- ☐ Are healthcare workers (if YES, are they screened regularly? _____).
- ☐ None of the above.

Parental Authorization

I, _____, as the parent or legal guardian of the patient, give permission to the following person to bring my child to be treated and vaccinated at the Starfish Pediatrics office.

Full Name: _____

Full Name: _____

I hereby authorize Starfish Pediatrics to treat my child.

Date: _____ **Parent or Guardian Signature:** _____



Receipt of Notice of Privacy Practices

WRITTEN ACKNOWLEDGMENT

Child's Name: _____

I, _____, have received all of the office information, as well as my rights and obligations. Please print your name.

NOTICE OF PRIVACY PRACTICES — STARFISH PEDIATRICS

Patient, Parent, or Guardian Signature: _____ Date: _____



Financial Policy

We are committed to providing you with the best possible care and are available to discuss our professional fees with you at any time. Your understanding of our FINANCIAL POLICY is important to our professional relationship.

Please read this document and sign to indicate your acceptance.

REGARDING HEALTH INSURANCE: As a courtesy, we will bill your insurance company. It is your responsibility to provide us with complete health insurance information and to be familiar with the terms of your policy. The contract and requirements are discussed directly between you and your insurance company. We do not get involved in disputes between you and your insurance company. You are responsible for timely payment for your visit.

FULL PAYMENT IS REQUIRED AT THE TIME OF THE VISIT: Copayments are collected prior to your visit, and any additional amount will be calculated and must be paid when you leave the appointment.

WE ACCEPT CASH, VISA, MASTERCARD, AND DEBIT CARDS.

BILLING POLICY: Statements are sent to the children's primary residence. If you have an emergency or a problem with payment, please call our billing department to discuss payment arrangements. There is a \$30 fee for late payments, and we reserve the right to charge additional interest.

FINANCIAL RESPONSIBILITY: The person who brings the patient will be responsible for paying at the time of the visit. We do not get involved in divorce agreements.

MINORS SEEN AT OUR OFFICE: An adult must accompany minor patients. If your children have a driver's license and you wish for them to be seen without you present, please contact the office before arriving for prior approval. Payment must still be made at the time of service.

MISSED APPOINTMENTS: A \$50 no-show fee will be charged for all missed appointments that are not canceled at least 24 hours in advance. We try to remind patients of their appointment date and time through notifications, but even if we are unable to reach you, it is still your responsibility to attend your appointment.

LATE CHARGES: If you fail to pay properly and on time, your account may be sent to a debt collection agency. You will be responsible for any balance and any collection costs of up to 50% of the balance due. If your account must be sent to the debt collection agency, your child and siblings will be automatically dismissed from the practice.

I have read all of the information and agree to the above. _____
DATE _____

I have received a copy of the Starfish Pediatrics Privacy Policy. _____ DATE _____

Names of all your children: _____



Immunizations / Vaccines

We want to make sure all of our patients and families are as healthy as possible, and we firmly believe that vaccines play a fundamental role in your child's health. Scientific research has clearly shown that vaccines are safe and effective. Not vaccinating a child puts not only that child at risk, but also everyone they come into contact with. This includes other children who are too young to be vaccinated or who cannot be vaccinated due to serious illness.

Our policy is to vaccinate infants, children, and adolescents according to the vaccination schedule recommended by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the State of Florida. All patients of the practice MUST receive all recommended doses of vaccines.

Please contact us if you have any questions, doubts, or concerns about vaccines. If you, as a parent, do not believe vaccines are something you want for your child, we regret that we would kindly ask you to find a different pediatric practice that better suits your philosophy.

Starfish Pediatrics — Vaccine Schedule Since 2024

IMMUNIZATION	1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YRS	4 YRS	11 YRS	12-18 YRS
Hepatitis B (Hep B)	#1	#2		#3								
Diphtheria, Tetanus, Pertussis (DTaP)		#1	#2	#3				#4				
Haemophilus Influenzae (Hib)		#1	#2	#3		#4						
Inactivated Polio (IPV)		#1	#2	#3						#5		
Pneumococcal (PCV)		#1	#2	#3		#4						
Rotavirus (Rota)		#1	#2	#3								
Hepatitis A (Hep A)						#1		#2				
Measles, Mumps, Rubella (MMR)						#1				#2		
Varicella (VZV)						#1				#2		
Tetanus, Diphtheria, Pertussis (TDaP)											#1	
Meningococcal Meningitis (Men A)											#1	#2 (age 16)
Meningitis B (Men B)												#1 (2 doses, age 16)

I Accept Immunizations _____ Modify Schedule _____ I Decline Immunizations _____

SIGNATURE: _____ DATE: _____



Treatment Authorization

Consent to Treatment

I acknowledge that I need the medical services of the office. I consent to receive care at the Starfish Pediatrics office from its physicians and assistants. I understand that the practice of medicine is not an exact science and that treatment and/or prescribed medication may involve risks and side effects. I understand that I will be informed of the availability of alternative modes of treatment or procedures and their benefits and risks, including no treatment at all, except in emergencies.

Use of Medical Information

I understand that, in accordance with federal and Florida law, Starfish Pediatrics will share all medical information as necessary for continuity of care and with any other institution or person as permitted by law. As an example, I understand that Starfish Pediatrics does not have an in-house laboratory and uses an outside medical laboratory, and my lab work and personal information are shared in order to perform the tests requested. Your privacy and the confidentiality of your personal health information are important at Starfish Pediatrics. Policies are in place to ensure that your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves this office, whether electronically, by fax, or on paper, without the patient's specific authorization.

We do not perform school or sports physical exams until the second visit, once the patient is already registered in the system and their entire medical history has been updated.

I have read and understand, to my complete satisfaction, this entire document, which consists of the consent to treatment and the use of my medical, personal, and financial information. I have had the opportunity to ask questions and receive answers. I also authorize the release of any necessary medical information of any kind to Starfish Pediatrics.

Signature: _____ **Date:** _____

Please print your name and indicate your relationship to the patient (if you are not the patient): _____

