Community Medical Center of West Volusia, P.A.
Rural Health Clinic

Patient Information – Pediatrics Deland
(*Please print clearly*)

Today's Date: _____/_____/_____

Child's Name: _____

Date of birth: _____/_____/_____ **S.S. #:** _____-_____-_____

Gender: M F **Ethnicity:** ( )Hispanic/Latino ( )Non-Hispanic/Latino ( )Refuse to Answer

Race : ( )Black/African American ( )White ( )Hispanic/Latino ( )Other _____

Preferred Language: ( )English ( )Spanish ( )Other _____

Mother's Name: _____ **DOB:** _____ **Contact Info:** _____

Father's Name: _____ **DOB:** _____ **Contact Info:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone (1st): _____ **Phone (2nd):** _____ **Email:** _____

Insurance: _____ **Phone:** _____

Policy #: _____ **Group #:** _____

Name of Policy Holder: _____

Relationship: _____

Legal Guardian/Health Care Proxy (*An individual designated by the family or by the courts to make health care decisions for the patient if the patient is unable to do so.***):** _____

Parent/Guardian Occupation : _____

Employment Address : _____

Emergency Contact Name: _____

Relation: _____ **Phone #:** _____

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the coverage. It is your responsibility to pay the deductible amount, co-insurance or any other balance not paid for by the insurance company. In order to control cost billing, we request that your charges for office visit be paid at each visit.

I understand that I am financially responsible for charges whether or not paid by said insurance company. I understand by signing this, I am authorizing treatment by the Community Medical Center of West Volusia, P.A.

Signature: _____ **Date:** _____

1190 NORTH STONE STREET ● DELAND, FL 32720 ● OFFICE: (386) 738-1792 ● FAX: (386) 738-4865
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Statement to Permit Payment to the Health Clinic for Services and Authorization to Release Information

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Medicare program and/or Social Security Administration or its intermediaries or carriers of any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. A photocopy is to be considered as valid as the original.

Signature: _____ **Date:** _____

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PEDIATRICS HEALTH HISTORY AND PHYSICAL

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

Obstetrician/Hospital: _____ **School :** _____

Healthcare Providers: _____ **Referred by:** _____

Current Health Concerns/Complaints: _____

_____

Do you have any known drug allergies? _____ **If yes, please list:**_____

Date/s of Previous Clinical Visits : _____

FAMILY	AGE	NAMES
FATHER		
MOTHER		
SIBLING ☐ M ☐ F		
SIBLING ☐ M ☐ F		
SIBLING ☐ M ☐ F		
SIBLING ☐ M ☐ F		
SIBLING ☐ M ☐ F		

FAMILY HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Allergies	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness/ Retardation	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
S.I.D.S.	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

BIRTH HISTORY

Mother's Blood Type: _____ **RH + - :** _____ **Type of Delivery :**_____

Term: _____ **Labor:** _____ **Apgar:** _____ **Birth Weight :** _____

Length: _____ **Discharge Wt:** _____ **Condition:**_____ **Circumcision** ☐ **Y** ☐ **N**

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GENERAL HEALTH HISTORY

☐ Chicken Pox	☐ Rubella	☐ Tonsillitis
☐ Pertussis	☐ Scarlet Fever	☐ Seizures
☐ Measles	☐ Frequent Colds/Pharyngitis	☐ Injuries
☐ Mumps	☐ Ear Infection	☐ Others
☐ Hospitalized (Please Specify) :		

Milestones	Age	Milestones	Age	Feeding/Nutrition
Held head Up		Sentences		BREASTS ☐ Quantity How Often? _____
Sat Alone		Teeth		FORMULA ☐ Quantity How Often? _____
Crept		Toilet Trained		VITAMINS ☐ Quantity How Often? _____
Walked		School Grade		FLOURIDE ☐ Quantity How Often? _____
Words		Bicycle		FOOD ALLERGIES ☐ Please list _____ _____

HABITS	TEST	DATE	TEST	DATE
SLEEP/NAPS	☐ Hearing		☐ Urinalysis	
BEDWETTING	☐ Vision		☐ Lead	
PLAY	☐ Hbg/Hct		☐ Others	
SCHOOL	☐ Chol/Trig			

MEDICATIONS	ALLERGIES

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AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

To : _____
Doctor or Hospital

Address : _____
Street **City** **State** **Zip Code**

Tel #: _____ **Fax#:** _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORDS TO :

Community Medical Center of W Volusia, P.A.
1190 N Stone Street
Deland, FL 32720
Tel # 386-7381792
Fax # 386-738-4865

The complete medical history in your possession, concerning my illness (including diagnostic reports, drug or alcohol abuse, HIV, and psychiatric) and/or treatment during the period from _____to _____ for the purpose of continuing care.

This authorization will remain in effect for 60 days. I may revoke this authorization at anytime in writing, but, if I do, it will not affect any actions taken prior to receiving the revocation. *I understand this authorization extends to the release of information via US mail, telephone, or facsimile machine (fax).*

Please Print:

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

Address : _____
Street **City** **State** **Zip Code**

_____ _____
Printed Name and Signature of Parent or Legal Representative **Date**

_____ _____
Witness **Date**

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SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

_____ _____

Patient Signature **Date**

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PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **NOTICE OF PRIVACY PRACTICES SUMMARY** which provides a description of information uses and disclosure. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I requested.

This page once signed will be placed in my records as written acknowledgement or receipt of the **NOTICE OF PRIVACY PRACTICES SUMMARY.**

Please Print:

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

Address : _____

Street **City** **State** **Zip Code**

_____ _____

Printed Name and Signature of Parent or Legal Representative **Date**

_____ _____

Witness **Date**

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NOTICE OF PRIVACY PRACTICES SUMMARY

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At the office of COMMUNITY MEDICAL CENTER; we have always kept your information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of our services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operation. For example, one of our staff will enter your Information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. We may want o call you about results of tests. If you are not home, we may leave this information on your answering machine or wit the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your written authorization.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

As we will need to contact you from time to time we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your record, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give to us in writing. We may or we may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of health and Human Services, 200 Independence Avenue, S.W. Room 509 P., Washington , D.C. 20201. You will not be retaliated against for filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer or Office Manager @ 386-775-1792.

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