



FLORIDA PEDIATRIC PULMONOLOGY

15740 New Hampshire Court, Suite B
Fort Myers, FL 33908

PATIENT REGISTRATION FORM

PATIENT'S LEGAL NAME:
DATE OF BIRTH: AGE: M/F SSN:
MAILING ADDRESS:
CITY, STATE, ZIP:
REFERRING DOCTOR:

PARENT OR GUARDIAN:
FATHER'S NAME: SSN:
EMPLOYER:
ADDRESS: PHONE# ()
MOTHER'S NAME: SSN:
EMPLOYER:
ADDRESS: PHONE# ()

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE:
ADDRESS:
CITY, STATE, ZIP:
PHONE#: () SUBSCRIBER:
SUBSCRIBER SSN: DATE OF BIRTH:

NAME OF SECONDARY INSURANCE:
ADDRESS:
CITY, STATE, ZIP:
PHONE#: () SUBSCRIBER:
SUBSCRIBER SSN: DATE OF BIRTH:

EMERGENCY CONTACT INFORMATION

NAME: RELATION TO PATIENT:
HOME PHONE: () WORK PHONE: ()
MOBILE PHONE: ()

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ ASSIGNMENT OF BENEFITS

I AUTHORIZE FLORIDA PEDIATRIC PULMONOLOGY TO FURNISH MEDICAL INFORMATION TO MY INSURANCE CARRIER RELATING TO THE MEDICAL CARE RENDERED BY.

I HEREBY AUTHORIZE FLORIDA PEDIATRIC PULMONOLOGY TO GIVE MY MINOR CHILD THE NECESSARY TREATMENT HE or SHE MAY NEED.

I AUTHORIZE PAYMENTS OF MEDICAL BENEFITS TO FLORIDA PEDIATRIC PULMONOLOGY FOR ANY MEDICAL CARE RENDERED TO MYSELF OR TO MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE

DATE



Florida Pediatric
Pulmonology
Luis A. Faverio, MD, FAAP
Board Certified

DISCLOSURE AGREEMENT AND RESPONSILITIES OF PATIENTS.

Thank you for choosing Florida Pediatric Pulmonology (FPP) as your health care provider. FPP is committed to your treatment being successful.

The following is a disclosure agreement and responsibility of patients, which **FPP requires you to read and sign prior to any treatment:**

- FPP cannot bill your insurance company unless you provide all the information needed to do so.
- The Insured or The Parent/Guardian will make every effort to understand the benefits of the insurance plan, even to the extent of calling the carrier, or the Primary Care Physician to insure that your benefits are received in a timely manner.
- If the plan is an HMO insurance that requires an authorization, it is the Patient/Guardians responsibility to obtain that first authorization.
- The Parent/Guardian is ultimately responsible for payment of services, including services that are not covered by the insurance company.
- The Parent/Guardian agrees to be on time for appointment and agree to pay a **\$50.00 charge for any missed appointments** if there is a failure to notify the office 24 hours in advance.
- The Parent/Guardian is responsible for co-payment at the time of the appointment. If there is a failure to do so, **FPP** has the right to bill Parent/Guardian for the co- payment amount.
- The Patient records will be held in strict confidence and will only be released upon written notification from Parents/Guardian.

I acknowledge that I have received Florida Pediatric Pulmonology's Notice of disclosure agreement and responsibilities of patients. I agree with the above.

Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____

Name of Patient: _____ Date of Birth: _____

Ft. Myers Office - 15740 New Hampshire Court, Suite B - Ft. Myers, FL 33908
Naples Office - 1665 Medical Blvd - Naples, FL 34110
Phone (239) 466-1243 - Fax (239) 466-6405



USE AND DISCLOSURE OF THE PROTECTED HEALTH INFORMATION

In general, the **HIPAA privacy rule** gives individuals the right to request a restriction on the use and disclosure of their protected health information. The individual is also provided the right to request confidential communication or that a communication of the protected health information be made by alternative means, such as sending correspondence to the individual's home.

I want to be contacted in the following manner:

- Home Telephone: _____ Cell Telephone: _____
- Leave test results and messages on answering machine.
- Leave message to call back office for test results with number only.
- Leave test results and message with a family member. Specify whom: _____
- Contact me personally with the test results or messages.
- Work Telephone: _____
- Leave test results and messages on answering machine.
- Leave message to call back office for test results with number only.
- Leave test results and message with a co-worker. Specify whom: _____
- Contact me personally with the test results or messages.
- Written Communication
- Mail to my home address only.
- Mail to my work address only.
- Fax to my home only. Specify fax number: _____
- Fax to my work address only. Specify fax number: _____

Child's Name: _____ Date: _____

Parent/Guardian Signature: _____

The **HIPAA privacy rule** generally requires health care providers to take reasonable steps to limit use and disclosures of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the uses and disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of protected health information disclosures.



Medical Record #: _____

Date of Visit: _____

PEDIATRIC PULMONOLOGY NEW PATIENT QUESTIONNAIRE

Name: _____ Birth Date: _____ Age: _____

Referring Doctor: _____ Patient's other doctors: _____

Reason for visit (describe briefly) _____

CHEST SYMPTOMS:

Age of onset of earliest symptoms: _____

Wheezing N / Y _____
 Tightness in chest N / Y _____

Cough N / Y _____
 Dry N / Y _____
 Productive (of mucus) N / Y _____
 Daily N / Y _____
 Periodic/Nocturnal N / Y _____
 Worse during the day N / Y _____

Chest Pain N / Y _____

Shortness of breath N / Y _____
 With exercise N / Y _____
 With changes in weather N / Y _____
 Anytime N / Y _____

Vomiting with coughing N / Y _____
 Spitting up or reflux N / Y _____

Fever N / Y _____
 Night Sweats N / Y _____
 Chills N / Y _____

Frequency of chest symptoms: Daily: _____ Weekly: _____ Monthly: _____ Nocturnal: _____

Time of year when symptoms are worse: _____

What are symptoms aggravated by? _____

Frequency of colds or upper respiratory tract infections

Per year: 1-3: _____ 3-6: _____ More than 6: _____

Would you classify your child's infections as: Throat: _____ Ear: _____ Sinuses: _____ Bronchitis: _____

Had your child ever had pneumonia? N / Y, Date: _____

Tonsillectomy and/or adenoidectomy? N / Y, Date: _____

NASAL SYMPTOMS:

Age of onset of earliest symptoms: _____

Frequency of symptoms: Constant _____ Seasonal _____

Times of year symptoms are worse _____

Nasal symptoms lead to chest symptoms: N / Y Describe nasal secretions: _____

What are symptoms aggravated by? _____

Symptoms worse in certain places? N / Y, where? _____



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Has your child ever received treatment for:

| | | | |
|-----------------------------|-------|---------------|-------|
| Remarkable nose bleeds | N / Y | Sinus X-rays | N / Y |
| Nasal polyp | N / Y | Sinus surgery | N / Y |
| Nasal septal deformity | N / Y | Broken nose | N / Y |
| Sinusitis (sinus infection) | N / Y | | |

EYE SYMPTOMS:

Does your child have eye symptoms? N / Y, If yes, please explain _____

What aggravates symptoms? _____

EAR SYMPTOMS:

Does your child have ear problems? N / Y, If yes, please explain _____

Has your child had ear tubes placed? N / Y

When? _____

HEADACHES:

Does your child have headaches? N / Y

Frequency: Rare _____ Daily _____ Weekly _____ Monthly _____

Severity: Mild _____ Moderate _____ Sever _____ Throbbing _____

SKIN RASHES:

N / Y, If yes, please explain _____

Has your child ever had hives? N / Y _____

List things that cause child's hives _____

FOOD PROBLEMS:

Is your child allergic to any foods? N / Y If yes, please explain _____

Is your child intolerant of any foods? N / Y If yes, please explain _____

Please list:

| FOOD | DATE | REACTION |
|------|------|----------|
| | | |
| | | |
| | | |
| | | |

INSECT SENSITIVITY:

Has your child ever had severe reactions from insect bites or stings? N / Y

Description of symptoms: Swelling: N / Y Breathing difficulties: N / Y

Hives: N / Y Fainting: N / Y

Other symptoms: _____

Any other allergies? Do not include medications _____

ENVIRONMENTAL SURVEY:

Time lived in present home? _____ Approximately how old is the home? _____

House / Apartment _____ City / Rural _____

Heat? N / Y Central _____ Space heater(s) _____ Do you use an electric air filter? N / Y

Does anybody that live in your child's household smoke? N / Y, who? _____

Is your child in school or daycare? N / Y, how many days a week? _____

BEDROOM: Pillows: Feather? _____ Foam? _____ Fiber filled? _____ Is pillow encased? N / Y

Bed coverings: What are they mode of? _____ Any feather filled items? N / Y

Mattress: How old? _____ Covered by: Cotton _____ Vinyl _____ Other _____



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Stuffed animals? N / Y Carpeting? N / Y Ceiling Fans? N / Y Pets _____
 Window coverings: Curtains _____ Blinds _____ (horizontal or vertical) Shades _____
 Do you use a vaporizer or humidifier in your child's room? N / Y When? _____
 Has your child ever had allergy tests and/or treatment? N / Y, if so, by whom _____

Location of previous residences:
 City _____ Symptoms better, worse, or the same? _____

BIRTH HISTORY:

Full Term? N / Y _____ Birth weight _____ any complications? _____

DIET: _____ **APPETITE:** Good / Fair / Poor. Explain: _____

STOOLS: Formed _____ Loose _____ Oily _____ Foul Smelling N / Y # of Stools/day _____

Any problems with constipation or diarrhea? _____

PAST MEDICAL HISTORY:

Ever been in the intensive care unit? _____ Ever been on a respirator? _____

| List all hospitalizations / operations / emergency room visits | Date | Diagnosis |
|--|-------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Any family medical history of asthma, lung problems, allergies/hay fever, sinus problems, Cystic fibrosis, Tuberculosis or recurrent infections? Explain

Does your child have any medication allergies? N / Y. Explain reaction, drug name or approximate date

Are your child's immunizations up to date? N / Y _____

FLU vaccine: N / Y, date of last _____ Pneumovax / Prevnar vaccine: N / Y, date of last _____

Please list all meds currently using (prescribed and over the counter):

| Medication | Dose | How often used | Helpful (N / Y) |
|------------|-------|----------------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

In the space below, describe any other symptoms / conditions that were not covered in this questionnaire.

