CHILD HEALTH HISTORY QUESTIONNAIRE

Please complete this to the best of you abilities, this will help us to better care for your child.

Name: (Last, First, MI) ____________________

Childs Previous Pediatrician: ____________________ Date of last physical exam:

A. Birth History

1. Who was the Mother's obstetrician? : __________ Date begun: __________
2. Any problems with the pregnancy? YES NO
3. Full term? YES NO
   If not full term, how many weeks? __________
   What was baby's birth weight? : __________ length? __________
4. Delivered at: (Name of Hospital) ____________________
   Vaginal __________ C-section __________
5. Problems at delivery?
   Mother? YES NO Baby? YES NO
   Type of problem ____________________
6. Do you know if Tobacco, alcohol, or drugs were used during pregnancy by the mother? YES NO

B. Past Medical History

1. Where has your child gone for checkups? __________
2. Date of last visit to Doctor: __________
   Dentist: __________
3. Allergy to: ____________________
4. Any reactions to shots? YES NO

Please explain: ____________________

5. Any hospitalizations, accidents, injuries? YES NO
6. Is child taking medicines? YES NO
   What kind? __________

C. FEEDING & NUTRITION

1. Is your child's appetite usually good? YES NO
2. Any colic, spitting, feeding problems? YES NO
3. Check: Breast Bottle Type of formula __________
4. Does your child eat things that are not food? YES NO
   What? ____________________

D. DEVELOPMENT & BEHAVIOR

1. At what age did your child sit alone? __________
2. At what age did your child walk alone? __________
3. Did your child say words by 18 months? YES NO
4. At what age was your child toilet trained? __________
5. Does your child wet the bed? YES NO
6. Does your child have trouble sleeping? YES NO
7. Does your child play well with others? YES NO
8. Has your child repeated a grade in school? YES NO

CHILD HEALTH HISTORY QUESTIONNAIRE

D. DEVELOPMENT & BEHAVIOR (continued)

9. What grade level is your child in at school? ____________

10. What kind of grades is your child getting in school? *A, B, C, D, F*

E. SAFETY & ENVIRONMENT

1. Where does the family live? House Apartment Mobile home Other ______
2. How many people live in the home? ____________ Language spoken in home? ______
3. Who takes care of the child most of the time? Parent relative babysitter daycare other
4. Is there a working smoke detector on each floor? YES NO
5. Does anyone in the household smoke? YES NO
6. What type of drinking water does the home have? county/city well bottled
7. Have you ever suspected your child has been mistreated? YES NO
8. Are there guns in the home? YES NO

F. FAMILY & CHILD MEDICAL HISTORY

Check any health problems for child, child's parents, grandparent's, brothers, sisters, aunts and uncles.

	Child	Family		Child	Family
Allergies			Hepatitis/Liver Disease		
Anemia-Low Blood Iron			High Blood Pressure		
Asthma/Bronchitis/Pneumonia			HIV/AIDS		
Birth defects/Retardation			Learning problems/ADHD		
Bladder/Kidney Problems			Mental illness/Suicide		
Cancer			Muscle/Joint/Bone pain		
Dental problems			Sexually transmitted diseases		
Diabetes (sugar)			Skin Problems		
Diarrhea/Constipation			Sore throat/Frequent colds		
Drug/Alcohol/Tobacco use			Thalassemia/Sickle cell		
Ear Problems/Tubes/Deafness			Tuberculosis		
Epilepsy/Seizures			Vision/Eye problems		
Heart problems/Murmurs			Other		

NUTRITIONAL SUPPLEMENT INFORMATION:

1. Is your child presently taking any type of nutritional supplements?
   (Such as vitamins, minerals, herbs, amino acids, fish oils, etc)? YES NO

Name the supplements they are presently taking?

2. Who recommended you to take these supplements? ____________
3. Where did you purchase these supplements? ____________
4. If this Practice offered an advanced, high quality line of supplements, would you consider purchasing them?
   YES NO

Nutritional supplement information: (continued)

5. If this Practice offered natural alternatives to prescriptions, when applicable, would you be interested in these alternatives? YES NO
6. If this Practice offered a comprehensive weight management program, would you consider it? YES NO
7. If this Practice offered a nutrition education program to improve your dietary habits, would you consider it?
   by appointment with one of our staff? YES NO
   by a class exclusively for our patients? YES NO

______________________________ Date: ____________

PRINT NAME PLEASE (Relationship)

WESLEYCHAPEL
INTERNAL MEDICINE AND PEDIATRICS
Manish Shah MD, FAAP

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Cell Phone: ( )	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Aetna	❑ Blue Cross	❑ Cigna	❑ Citrus H/C	❑ Medicaid
❑ Medicare	❑ Medipass	❑ Tri-Care	❑ United health Care	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
Phone: 813-929-3622 Fax: 813-929-3620

Office Policies

Last updated 4/2018

Dear Patient or Parent/Guardian,

As a part of ongoing effort to make being at our office a pleasurable experience, we have adopted some standard policies to ensure your continued satisfaction with our services.

1. We are here to take care of you. **The office is open Monday – Friday from 8am to 5pm**.
2. We will make every attempt to see you when you are ill on the same day or the next day. Dr. Shah will occasionally overbook appointments for this purpose.
3. We attempt sincerely to see you on time. If the wait to be seen is expected to exceed 30 minutes, you should and will be notified. Please be patient as we do try to make room for everyone in the schedule when they are ill.
4. If you are unable to keep an appointment, we ask that you re-schedule at least 24 hours prior to your appointment time. If you no-show for an appointment or cancel within 24 hours of the appointment time, there will be a **no-show/untimely cancellation fee of $35** charged to your account. Excessive no-shows or untimely cancellations for appointments may result in dismissal from the office at the discretion of Dr. Shah.
5. Please give us at least **1-week notice for medication refills**. (Most prescription refill requests are done within 24-72 hours of your phone call.)
6. You should always receive a call regarding results of labs and other tests that Dr. Shah orders for you. If you do not receive a result, it is imperative that you call the office for the result. Every test is reviewed by a provider. Most labs and tests are reviewed within 24-72 hours of receiving the result. If it has been more than 10 days, please advise us immediately.
7. We do ask that non-health-related paperwork (e.g., FMLA, Disability, and Medicare-required paperwork) be filled out during an office visit. Please understand that these forms take time to fill out accurately, and your presence is necessary. **Please understand also that we charge an additional and separate fee of $35 for the completion of these additional forms.**
8. School Physicals & Gold and Blue forms will be filled out without requiring an additional office visit if the child has been seen here for a well child exam in the last 6 months. Please give us at least 48 hours notice to have these forms completed.
9. We ask that all children brought to the office act and behave appropriately for their age(s).
10. **Our After-Hours Phone Number to speak with Dr. Shah is (813) 681-0093**, to be used only for urgent medical care needs.
11. **All balances are due at the time of service. We ask that you make arrangements for all balances with us prior to your visit. Services will not be rendered, and you may be rescheduled if payment arrangements are not made. Any balances billed to insurance and not paid by or not covered by insurance, do become patient responsibility, and will be due at the time of service.**

We take pride in our work and our office, and we are always looking for suggestions for improvement. Please feel free to drop off any suggestions to our office. Any confidential requests can be discussed with Dr. Shah directly. Thank you, and Welcome to Wesley Chapel Internal Medicine and Pediatrics.

Patient Name (Please Print): ______________________________

Parent/Guardian Name (if applicable): ______________________________

Patient/Guardian Signature: ____________________ Date: ____________

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
Phone: 813-929-3622 Fax: 813-929-3620

Acknowledgement of Receipt of

Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of *Wesley Chapel Internal Medicine & Pediatrics PA's* Notice of Privacy Practices.

________________________ ________________________ ________________

Name (Please Print) Signature Date

If signing as a parent or guardian, please print the name of the patient below.

____

Name (if minor or unable to sign)

** FOR INTERNAL OFFICE USE ONLY **

Date Acknowledgement received: ________________________
Or
Reason(s) Acknowledgement was/were not obtained:

____

____

____

____

________________________ ________________________ ________________

Name (Please Print) Signature Date

WESLEYCHAPEL
INTERNAL MEDICINE AND PEDIATRICS
Manish Shah MD, FAAP

Notice of Privacy Practices

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

At our practice, we will always keep your health 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 your 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 operations. 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 written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In case 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.

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

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above 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 also want a copy of your records, we may charge you a reasonable fee for these 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 it to us in writing. We may or 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 document, but will add additional information.

You have a 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 service 200 Independence Avenue, S.W. , Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy officer, Dr. Shah, phone number 813-929-3622.

This notice goes into effect as of the opening of this office in April 2006.

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ OUR NOTICE OF PRIVACY PRACTICES.

X ____

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
Phone: 813-929-3622 Fax: 813-929-3620

Permission to Disclose Information

Due to the **Health Insurance Portability and Accountability Act (HIPAA)**, we are not allowed to disclose your health information to anyone without your written permission.

Please list below the names of those whom you will allow us to share your health information.

Name (Please Print):	Relationship:
______________________________	______________
______________________________	______________
______________________________	______________

Patient Name (Please Print): ______________________________

Patient/Guardian Signature: ____________________ Date: ______________

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
Phone: 813-929-3622 Fax: 813-929-3620

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name: Social Security #:

I request and authorize
(Name of Previous Doctor):

(Previous Dr.'s Phone #) **(Previous Dr.'s Fax #)**

To release healthcare information of the patient named above to:

Name: Wesley Chapel Internal Medicine & Pediatrics

Address: 2038 Ashley Oaks Circle Suite #102

City: Wesley Chapel State: FL Zip Code: 33543

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ All healthcare information

☐ Other:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: Date Signed:

WESLEYCHAPEL

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
Phone: 813-929-3622 Fax: 813-929-3620

Patient Name: ____

Please tell us how you heard about Our Practice:

- ☐ Patient Referred (please tell us who, and we will send them our gratitude): ____________________
- ☐ Physician Referred: ______________________________________
- ☐ Insurance Company (Website): ______________________________
- ☐ Newspaper Ad (name of newspaper): ____________________________
- ☐ Yellow Pages: ____
- ☐ Internet Search (please indicate Yahoo, Google, etc.): __________________
- ☐ Other (please indicate): ______________________________________

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
Phone: 813-929-3622 Fax: 813-929-3620

Patient Portal

Convenient, safe, and secure patient connectivity website allows you to communicate with your provider's office anytime—day or night.

Our goal is to be your first choice in patient healthcare by providing convenience and accessibility to our practice. **The Patient Portal offers our patients online health services that include the ability to request appointments, request medication renewals, access medical information, and access laboratory results.**

Your medical information is available to you on this website and is secure. Our company and its affiliates, suppliers, and other third parties mentioned on this site are neither responsible nor liable for any direct, indirect, incidental, consequential, special, exemplary, punitive, or other damages (including, without limitation, those resulting from lost profits, lost data, or business interruption) arising out of or relating in any way to the site, site-related services and products, content, or information contained within the "site," and/or any hyperlinked website, whether based on warranty, contract, tort, or any other legal theory, and whether or not advised of the possibility of such damages. Your sole remedy for dissatisfaction with the site, site-related services, and/or hyperlinked web sites is to stop using the site and/or those services applicable law may not allow the exclusion or limitation of incidental or consequential damages, so the above limitation or exclusion may not apply to you.

Patient Name (Please Print): ____

Patient/Guardian Signature: ____________________________ Date: ____________________

Email Address (Please Print Clearly): ____

☐ **Decline Portal Use** (Please still print your name, sign, and date above)