Ellenton Pediatrics

Cristian Chiritescu, MD, FAAP
Alina Chiritescu, MD, FAAP
Jessica M. Zeller, ARNP, CPNP
Jessica R. Eastman, ARNP, CPNP

8425 US Highway 301 North • Parrish, Florida 34219 • www.EllentonPeds.com
Office 941-723-7877 • Fax 941-723-7844

NEW PATIENT REGISTRATION

(To be printed by a parent, filled out and taken to Ellenton Pediatrics at your first visit.)

Today's Date:	**Who referred you to our office?**		
PATIENT'S INFORMATION - Please provide the receptionist your insurance card and photo identification to photocopy.			
Child's Legal Last Name:	First Name:	Middle:	Nickname:
Birth Date:	Birth Weight:	Age:	Sex: ☐ Male ☐ Female
Address:	Post Office:	City/State/ZIP Code:	
Primary Language:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	Race: ☐ Asian ☐ Black ☐ Hawaiian ☐ White	
If adults in the household work outside the home, what child care arrangements are made for this child?			
Sibling's Name and Age:	Sibling's Name and Age:	Sibling's Name and Age:	Sibling's Name and Age:
PARENTS' INFORMATION - Please inform the receptionist if any of the information listed on this form changes in the future.			
Mother's Legal Last Name:	First Name:	Maiden Name:	Birth Date:
Age at Birth of Patient:	Home Telephone:	Cell:	Email:
Occupation:	Employer:		Employer Phone:
Father's Legal Last Name:	First:	Middle:	Birth Date:
Home Telephone:	Cell:	Email:	
Occupation:	Employer:		Employer Phone:

PREGNANCY AND BIRTH INFORMATION

Medical problems during this pregnancy (illnesses, infections, anemia, etc.): _____

_____

Was baby born within two weeks of expected day? ☐ Yes ☐ No ☐ Early ☐ Late

Delivery was: ☐ Spontaneous vaginal delivery ☐ Forceps ☐ Cesarean section

Where was the baby born? _____ How many days in the hospital? _____

Where there any complications for the baby while in the hospital? ☐ No ☐ Yes Explain below:

_____

Was baby breast fed? ☐ Yes, How long? _____ ☐ No

bg| 7-2016

PAST MEDICAL HISTORY

Where has your child gone for medical check-ups until now? _____

What is the date of his/her last medical checkup? _____ Are parents in good health? ☐ No ☐ Yes

What is the date of your child's last dental checkup? _____ Where? _____

Is your child taking any medications regularly? ☐ No ☐ Yes If so, which medications? _____

Any reactions to medications, foods, insect bites? ☐ No ☐ Yes If so, which ones? _____

Has your child had reactions to any immunizations? ☐ No ☐ Yes If so, which ones? _____

Any hospitalizations other than at birth? ☐ No ☐ Yes Age and reason for hospitalization: _____

Any serious injuries? ☐ No ☐ Yes Describe the injuries: _____

Does anyone in the household smoke? ☐ No ☐ Yes If so, whom? _____

Do you have any pets? ☐ No ☐ Yes If so, what kind? _____

Please check the boxes below if your child has had any of the following illnesses or injuries:

- ☐ Allergies
- ☐ Asthma or Recurrent Cough
- ☐ Broken Bone(s)
- ☐ Chickenpox
- ☐ Eye or Ear Problems
- ☐ Feeding or Eating Problems
- ☐ Hearing Problems
- ☐ Heart Murmur
- ☐ Knocked Unconscious
- ☐ Learning/Developmental Issues
- ☐ Measles or German Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Poison Ingestion
- ☐ Pneumonia
- ☐ Seizures
- ☐ Throat Problems or Tonsillitis
- ☐ Tooth Problems
- ☐ Urinary Problems
- ☐ Vision Problem

☐ Other illnesses or injuries your child has had: _____

FAMILY MEDICAL HISTORY

Please check the boxes below if there is any family history of the following conditions. Consider extended family such as aunts, uncles, cousins and grandparents.

- ☐ Allergies or Hay Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems (Thyroid, Lupus, Etc.)
- ☐ Birth Daformities
- ☐ Bleeding Tendencies (Hemophilia)
- ☐ Bone Disease
- ☐ Breathing or Lung Problems
- ☐ Cancer
- ☐ Colic
- ☐ Colitis
- ☐ Congenital Anomalies
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eye Problems
- ☐ Foot Problems
- ☐ Hearing Loss or Ear Trouble
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV or AIDS
- ☐ Kidney Disease
- ☐ Liver Disease (Hepatitis)
- ☐ Mental Illness
- ☐ Other Neurological Problems
- ☐ Scoliosis, Hip Dysplasia or Other Orthopedic Problems
- ☐ Seizures
- ☐ SIDS Or Other Infant Death
- ☐ Skin Problems
- ☐ Substance/Drug Abuse
- ☐ Tuberculosis
- ☐ Urine Infections
- ☐ Ulcers

☐ Other medical conditions in your family's history: _____

IN CASE OF EMERGENCY

1. Name of Local Friend or Relative (not living at the same address):		Relationship to Patient:
Home Telephone:	Work Telephone:	Cell:
2. Name of Local Friend or Relative (not living at the same address):		Relationship to Patient:
Home Telephone:	Work Telephone:	Cell:

INSURANCE INFORMATION - Please provide receptionist your insurance card and photo identification to photocopy.			
Person responsible for bill:		☐ Mother ☐ Father ☐ Other, what is your relationship to child?	
Address, if different from Page 1:		Home Phone:	Driver's License Number:
Occupation:	Employer:	Employer's Telephone:	Employer's Fax:
Employer Address:		Is the patient covered by insurance? ☐ No ☐ Yes	
Insurance Company:	Insurance Telephone:	Policy Number:	Group Number:
Insurance Company Address:		City/State/ZIP Code:	
Secondary Insurance Company:	Insurance Telephone:	Policy Number:	Group Number:
Secondary Insurance Company Address:		City/State/ZIP Code:	

CONTACTING YOU - How would you ideally prefer to be contacted by Ellenton Pediatrics regarding the following?				
Medical Issues:	☐ Home phone	☐ Work phone	☐ Cell phone	
Appointment reminders:	☐ Home phone	☐ Cell phone	☐ Home email	☐ Work email
General practice notices:	☐ Home address	☐ Home phone	☐ Cell phone	

PERMISSION TO TREAT • RELEASE OF MEDICAL INFORMATION FOR CLAIM PAYMENT • PAYMENT AGREEMENT

By the signature below, I hereby certify the correctness of the above information. As parent or legal guardian of the minor patient(s), I authorize the medical providers of Ellenton Pediatrics and any other physicians who are on call for Ellenton Pediatrics to evaluate and treat my child/children as deemed medically necessary.
As parent or legal guardian of the minor patient(s), I authorize Ellenton Pediatrics to release any medical information necessary for evaluation and treatment of the above named child/children by other physicians and/or specialists. I also authorize all other medical providers to release any medical information necessary for evaluation and treatment of the above named child/children to Ellenton Pediatrics.

I authorize release of any information necessary to complete any insurance claim and hereby authorize my insurance benefits to be paid directly to Ellenton Pediatrics. As parent or legal guardian of the minor patient(s), I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of this office (available from the business office). I will promptly pay any covered or non-covered charges not paid by my insurance company, including but not limited to, charges to my account for after hours telephone advice. Any dispute over said charges will be handled between me and my insurance company.
If it becomes necessary for the account to be referred to collective action, I shall pay the actual attorney's fees and collection expenses.

I have been informed that Ellenton Pediatrics' HIPAA Notice of Privacy Rights and Practices is posted in the office and I may have a copy upon request.

Signed _____ Date _____
Patient or Responsible Adult

Welcome To Ellenton Pediatrics

Ellenton Pediatrics

Cristian Chiritescu, MD, FAAP
Alina Chiritescu, MD, FAAP
Jessica M. Zeller, ARNP, CPNP
Jessica R. Eastman, ARNP, CPNP

8425 US Highway 301 North • Parrish, Florida 34219 • www.EllentonPeds.com
Office 941-723-7877 • Fax 941-723-7844

FINANCIAL POLICY

Your insurance is a contract between you and the insurance company. We are not a party to that contract. Not all services are covered benefits. We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we may extend to our patients, all charges are your responsibility from the date the services are rendered.

We will be happy to bill your insurance and will accept the assignment, however, any unmet deductible coinsurance and co-pay will be collected at the time service is rendered. Any difference will be included in our monthly statements and payment is expected upon receipt.

If there is an uncertainly regarding insurance coverage for services that we provided, we prefer that you contact your insurance carrier directly for benefits on your plan.

If Ellenton Pediatrics is a participating provider for your insurance company and your policy requires a written referral for any visit to the specialist it is your responsibility to inform us at least 48 hours before your appointment time, otherwise you will be responsible for the insurance denial of services provided by the specialist.

Payment for services is due at the time services are rendered. Any patient responsibility transferred by the your insurance is due immediately after it is determined by your insurance and communicated by us through our monthly statements. For your convenience, we offer the following methods of payment: personal checks in person or by mail and credit cards payments either in person or by telephone.

There will be a fee of $25 charged to the patient's account for missed appointments that were confirmed with the patient's parents or appointments canceled without at least eight hours advanced notice.

FINANCIAL ARRANGEMENTS

We expect payment in full at each appointment. All returned checks are subject to an additional $25 fee. **LATE FEES WILL BE ASSESSED ON ANY OUTSTANDING BALANCES DUE.**

AUTHORIZE AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers an/or other health practitioners.

I authorize and request my insurance company to pay directly to the physican or physician's group insurance benefits. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. I understand and accept that I am financially responsible for any and all charges incurred for professional services rendered to me. I also understand and accept that I am responsible for any charges incurred should collection proceeding become necessary to enforce that agreement. I have read and understand the above.

Parent's Signature _____ Date _____

PRIVACY POLICY NOTICE AND CONSENT

My signature below represents my understanding and willingness to comply with this policy. I acknowledge I have read and received a copy of the Ellenton Pediatric Privacy Policy brochure.

Parent's Signature _____ Date _____

Ellenton Pediatrics

Cristian Chiritescu, MD, FAAP
Alina Chiritescu, MD, FAAP
Jessica M. Zeller, ARNP, CPNP
Jessica R. Eastman, ARNP, CPNP

8425 US Highway 301 North • Parrish, Florida 34219 • www.EllentonPeds.com
Office 941-723-7877 • Fax 941-723-7844

PARENTAL AUTHORIZATION FORM
For Another Adult to Take a Child for Medical Treatment

I give permission for the following to authorize medical treatment for my child in the event that I am not available.

Child's Name _____ Date of Birth _____

List two people on the lines below other than a parent/guardian.

Name _____ Relation to Child _____

Name _____ Relation to Child _____

Parent's Name _____ Date _____

Parent's Signature _____ Telephone _____

NOTE: If, at any time, a person listed above no longer has your permission to authorize treatment or to take your child to Ellenton Pediatrics, it is your responsibility to inform us with a letter stating that you are withdrawing your permission.

Ellenton Pediatrics

Cristian Chiritescu, MD, FAAP
Alina Chiritescu, MD, FAAP
Jessica M. Zeller, ARNP, CPNP
Jessica R. Eastman, ARNP, CPNP

8425 US Highway 301 North • Parrish, Florida 34219 • www.EllentonPeds.com
Office 941-723-7877 • Fax 941-723-7844

RECORDS IN AUTHORIZATION
(Transfer of Patient Records From Previous Physician)

Date _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

As the parent or legal guardian, I authorize the physician listed below to furnish a copy of my child's/children's records of medical care and treatment, full detail including immunizatons, to Ellenton Pediatrics.

Previous Physician _____ Clinic Name _____

Physician's Phone _____ Physician's Fax _____

Please initial for requested records:

___ Immunizations ___ Consultations ___ Physical Exams ___ Labs, X-ray Results

Parent's Name _____ Telephone _____

Parent's Address _____

Parent's Signature _____

Witness _____ Witness's Signature _____

IF RECORDS ARE MORE THAN 50 PAGES PLEASE MAIL

Ellenton Pediatrics

Missed Appointment Policy

Missed appointments limit access to medical care for other patients. Office appointments cancelled with less than 4 hours notification, and arrivals more than 15 minutes-late are also considered missed appointments. We kindly request that you provide at least 4 hours cancellation-notice during business hours, so we can offer the time slot initially reserved for your child to another family who needs it. We understand that situations may arise in which you must miss your appointment, therefore we concede to one missed appointment occurrence for an already established patient, before this policy applies.

MISSED APPOINTMENTS ARE SUBJECT TO A $25 FEE.

1. After the first missed appointment, the patient will have to resign the missed appointment policy, as a reminder.
2. Patients who miss two (2) or more appointments within a 12-month - period, will be subject to a $25 fee. The missed appointment fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.
3. After three (3) missed appointments within a 12-month - period, we reserve the right to decline any further appointments.
Prospective patients who miss their first appointment will not be able to reschedule.
Our practice firmly believes that a successful provider - patient relationship is based upon understanding, good communication and mutual respect. We trust that you will be here for the time we scheduled just for your child.

- THANK YOU –

Please sign that you have read, understand and agree to this Missed Appointment Policy.

_____ **Date of birth** _____
Patient Name (Please Print)

_____ _____
Signature of Parent or Patient Representative **Date**

Ellenton Pediatrics

Patient Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

On behalf of the patient(s) listed above, I have been made aware of Ellenton Pediatrics policies and procedures and given written copies for my records.

I hereby give authorization for payment of insurance benefits to be made directly to Ellenton Pediatrics. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and authorize this healthcare provider to release all records and information necessary to secure payment of benefits.

My signature below represents my understanding and willingness to comply with this policy. I acknowledge I have read and received a copy of the Ellenton Pediatrics Privacy Policy brochure.

Parent / Guardian Signature: _____

Date: _____

Ellenton Pediatrics

Cristian Chiritescu, MD, FAAP
Alina Chiritescu, MD, FAAP
Ettaly F. Jobes, MD, FAAP
Jessica M. Zeller, ARNP, CPNP
Jessica R. Eastman, ARNP, CPNP

Ellenton Pediatrics would like to make you and your family aware of our new patient portal. This portal is an online tool used to connect our patient's guardians directly and secure to information you may need.

The portal includes the following features:

- Access to growth charts, immunization history, prescriptions, diagnostic test results and more.
- Guardians can update demographic and contact information, such as home address, email, and phone number.
- Two- way, HIPAA- complaint messaging for non urgent questions.
- Patients can view upcoming appointment times and dates.
- Submit request for prescription refills and Immunization/ School Entry Health Exam forms.

Please review the following and sign for which applies to you and your family:

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Yes, I am interested and would like Ellenton Pediatrics to provide me with the information to begin using my Patient Portal.

Parent/ Guardian Signature: _____ **Date:** _____

Email Address: _____

No thank you, I am aware of the Patient Portal but at this moment I will not be using the service.

Parent/ Guardian Signature: _____ **Date:** _____