Ocoee Pediatrics

55 25th Street Cleveland, TN. 37311
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Ocoeepeds.cleveland@gmail.com

Demographic Information

First Name		Middle Name		Last Name	
DOB		Sex		Primary Language	
Race	Caucasian or White African American or Black Asian American Indian or Alaskan Native Native Hawaiian or other Pacific Islander Other: _____			Ethnicity	Hispanic or Latino Non Hispanic or Latino
Social Security #		Email			
Street Address		City		State		Zip	
Primary Phone	Cell Home Work		Secondary Phone	Cell Home Work	
Please list siblings' names and ages					

Insurance

Primary Insurance Carrier		Name of Insurer & DOB	
ID #		Group #	
Secondary Insurance Carrier		Name of Insurer & DOB	
ID #		Group #	

Parent/Guardian Information

Name		DOB	
Relationship		Phone #	
Name		DOB	
Relationship		Phone #	

Release of Health Information my be provided to the following people

Name (First & Last)		Relationship	
Name (First & Last)		Relationship	

My child may be accompanied and discuss care needs by the following people

Name (First & Last)		Relationship	
Name (First & Last)		Relationship	

Emergency Contact Information (other than parents)

Name		Contact #		Relationship	
Name		Contact #		Relationship	

Prenatal History

While you were pregnant did you use alcohol?	YES NO	If yes, how much?	
While you were pregnant did you use tobacco?	YES NO	If yes, how much?	
While you were pregnant did you use any street drugs?	YES NO	If yes, how much?	
While you were pregnant did you have any medical problems?	YES NO	If yes, please explain:	
While you were pregnant did you take any medications?	YES NO	If yes, please list	
How many weeks were you when your baby was delivered?		Was your baby born C-section or Vaginal?	
Where was your baby delivered?		What is the name of the doctor that delivered your baby?	

Perinatal History			
Child's birth weight		Child's birth length	
How many days did your child stay in the hospital at birth?			
Were there any abnormalities or problems when your child was born?		(If yes, please explain)	
Did your child pass the Newborn hearing test?		YES NO	

History			
Has your child had any major illnesses?	YES NO	If yes, please explain	
Has your child had any surgeries?	YES NO	If yes, please list	
Please list any allergies your child has			
Please list any medications your child takes (and include dosage)			
Who does your child live with?			
Is your child exposed to 2nd hand smoke?			
Has your child ever smoked or currently smoking?	YES NO	Has your child ever used or currently using alcohol?	YES NO
Has your child ever used or currently using street drugs?	YES NO	Is your child sexually active?	YES NO

Family History

Med Condition	Mom	Dad	Sis	Bro	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis	Mom's Bro	Dad's Sis	Dad's Bro
Alcoholism												
Anemia												
Asthma												
Bleeding Disorder												
Cancer												
Birth Defect												
Heart Attack												
Depression												
Diabetes (Insulin Dependent)												
Diabetes (Non Insulin)												
Eczema												
Food Allergy												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Mental Illness/ Learning Disability												
Stroke												
Substance Abuse												
Thyroid Disorder												
Tobacco Use												
Tuberculosis												
Sudden Death before 55 yrs. of age												

Attestation

I understand the importance of a truthful health history to assist the clinician in providing the safest care possible.

_____ _____ _____

Signature of person completing history | Relationship to patient | Date

Ocoee Pediatrics Policies

-No call and no-show policy: If your child has 3 no calls and no shows you will be dismissed.

-If you are later than 15 minutes after your appointment you will have to be rescheduled.

-Well child visits are scheduled in the morning and sick appointments in the evening hours. This is so well children are not exposed to any illnesses.

-Any records including shot records take 3 business days to prepare.

-If your child destroys property of this office, you may be held financially responsible for damages.

-Foul language or rude behavior will not be tolerated in the office or on the telephone with office staff you will be dismissed.

-No controlled substances or antibiotics can be called in the pharmacy unless a patient is seen in our office. Any refills need to be requested three days in advance. Children must be up to date on well child visits to receive any refills.

-All patients must be accompanied by an adult over the age of 18 years old and be listed on the Ocoee Pediatrics Policies.

-During flu season (September-March) wait times may be longer due to flu tests taking 20-25 minutes to run. Please be patient while waiting as we want to treat children the best way possible and this is only able to be done when appropriate tests are run.

-All copays or balances are due before being seen. If you are unable to pay the full balance, half of the full balance is required and a payment plan will be set up.

-Immunization Policy: We encourage all parents to immunize their children according to the CDC schedule. Although we do not recommend alternate schedules, we will accommodate parents who choose this option and certainly prefer this over not immunizing at all. If at the 12 month well child visit you choose to decline all vaccinations you will be dismissed.

-School excuses can only be given for the day your child is seen at our office and any future days as determined by the provider seeing your child.

-We strive to be available for your child when sick for a same day appointment. Due to this you may be placed in a cubby area for triage and treatment if applicable. If you are not comfortable in a cubby setting, notify our staff and we will be happy to make other arrangements. Please note that there may be a longer wait period before being placed in a room.

-In efforts to ensure a safe environment, there may be times when we have to hold/restrain your child in order to medically treat and care for them.. Please note that this is necessary for the safety of you, your child, and our employees. If you do not feel comfortable or have concerns with the treatment process you may opt to have it done outside of our facility.

I do hereby consent to any medical care for my child provided by Ocoee Pediatrics

I have read and agree with Ocoee Pediatrics Policies and procedures.

Parent/Guardian Signature_____ Relationship:_____

Parent/Guardian Printed Name (first):_____(last)_____

Patient's Name:_____ Date of Birth:_____

Ocoee Pediatrics

HIPAA-ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices Printed Patient

Name: _____

Patient Date of Birth:_____

We at Ocoee Pediatrics are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____
Printed name of patient or patient's representative/parent

_____
Relationship to patient