Pediatric Pulmonary & Allergy Associates, P.A.

Jose A. Birriel, M.D.
Board Certified Specialist in Pediatric Pulmonary

Isaac Talmaciu, M.D.
Board Certified Specialist in Pediatric Pulmonary & Sleep Medicine

Melissa Cardenas Morales, M.D.
Board Certified Specialist in Pediatric Allergy & Immunology

Thank you for scheduling an appointment at our office.
Attached you will find our registration forms for your child's first appointment.
Please note that a parent or legal guardian must accompany the patient.

Necessary documents for your appointment:

- Parent/legal guardian's photo I.D.
- Current insurance card
- Referral if your insurance requires one
- Proof of legal guardianship if you are not biological parent (Ex: notarized letter/court papers)
- Payment must be made at time of service in the form of debit/credit card

Office Locations

- **Pembroke Pines**
  1 S.W. 129th Avenue, Suite #308
  Pembroke Pines, FL 33027
  Phone: 954-589-0805 / Fax: 954-668-2205
  - Located 1.5 miles East of I-75 & Pines Blvd.
  - On the S.E. corner of Pines Blvd. & 129th Ave.

- **Plantation**
  4100 N.W. 3rd Court, Suite #200
  (S. Hospital Drive)
  Plantation, FL 33317
  Phone: 954-583-1056 / Fax: 954-583-3173
  - Located West of S.R. 441 between Sunrise & Broward Blvd. on the grounds of Plantation General Hospital
  - Second left hand turn N. of Broward Blvd.

- **West Boca**
  9291 Glades Road, Suite #302
  Boca Raton, FL 33434
  Phone: 561-218-3399 / Fax: 561-218-3169
  - Located on the N. Side of Glades Road between S.R. 441 & the FL Turnpike
  - West of Lyons Road by Rooms to Go

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Patient Demographics

Today's Date: _____ /_____/_____

Patient's Name:_____ DOB: _____/_____/_____ Sex: ☐F ☐M

Name of person accompanying patient today:_____ Relation:_____

Patient's Address:_____

City:_____ State:_____ Zip:_____

Patient lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other _____

Pediatrician's Name:_____

Pediatrician's Phone #:_____ Fax:_____

Mother's Name:_____ ☐Biological ☐Stepmother ☐Other

Cell #:_____ Email:_____

Father's Name:_____ ☐Biological ☐Stepfather ☐Other

Cell #:_____ Email:_____

Emergency Contact:_____ Relation:_____
(Other than parent)

Cell #:_____ Home #:_____ Work #:_____

Staff Initials: _____

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Insurance Information

Primary Insurance: _____ 800 #: _____

Policy Holder: _____ DOB: _____ /_____ /_____

Relationship to Patient: _____

Identification #: _____ Group #: _____

Coordination of benefits: Is the patient covered by any other health insurance?

☐No ☐Yes (If yes, please fill out secondary insurance)

Secondary Insurance: _____ 800 #: _____

Policy Holder: _____ DOB: _____ /_____ /_____

Relationship to Patient: _____

Identification #: _____ Group #: _____

☐ **Self Pay:** I certify that I do not have any form of insurance _____

Signature

We invite you to discuss frankly with us any questions you may have regarding our staff and/or services. The best health service is based on a friendly, mutual understanding between doctor and patient. Our office policy requires that on today's visit you must pay your co-payment, outstanding deductible, and/or co-insurance, unless you have made prior arrangements with the office manager. Divorced parents: Please note that our office does not engage in any disputes or arrangements between divorced parents. The parent who brings the patient to the office visit is the party responsible for co-payments, outstanding deductible, and/or co-insurance. If you allow your account to become more than 120 days delinquent, without prior payment arrangement, your account may be reported to **Equifax Credit Bureau**. Once the account is reported to the credit bureau you may be responsible for a collection/processing fee of up to 40% of the outstanding balance, in addition to the amount owed.

Assignment of Benefits/Release of Information

I, the undersigned hereby authorize the release of any information including the diagnosis, psychological evaluation, HIV information, and the records of any treatment relating to all claims for benefits submitted on behalf of myself and/or dependent(s). I further expressly agree and acknowledge that my signature on this document authorizes Pediatric Pulmonary & Allergy Associates, PA to submit claims benefits, for services rendered or services to be rendered, without obtaining my signature on each and every claim to be submitted on behalf of myself and/or dependent(s), and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize the above named insurance company to assign directly to Pediatric Pulmonary & Allergy Associates, PA all benefits payable. I understand that I have not been released of liability, and that I am financially responsible for all charges incurred.

_____ **Date:** _____ / _____ /_____

Signature of Parent/Legal Guardian (Financially responsible for account)

_____ _____

Printed Name of Parent/Legal Guardian **Relationship to Patient**

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Consent for Release of Information, Payment, and Health Care Operations HIPAA

Patient's Name: _____ DOB: _____ /_____ /_____

I, _____ hereby authorize ***Pediatric Pulmonary & Allergy Associates, PA*** to
Parent/Legal Guardian
use and/or disclose the health information of the patient named herein, which specifically identifies the above named patient or which can reasonably be used to identify him/her to carry out treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, *Pediatric Pulmonary & Allergy Associates, PA* can refuse to treat the patient named herein. This consent may also be used if I should request a copy of the patient's medical records. I am aware that if I were to request a copy of these records, there will be a charge of $1.00 per page for any records that have previously been provided.

I have received a copy of the Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of my child's individual identifiable health information for treatment, payment, and health care operations.

I understand that I may revoke this consent at any time by notifying *Pediatric Pulmonary & Allergy Associates, PA* in writing, but if I revoke my consent, such revocation will not affect any actions that *Pediatric Pulmonary & Allergy Associates, PA* took before receiving my revocation.

I understand that *Pediatric Pulmonary & Allergy Associates, PA* has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that *Pediatric Pulmonary & Allergy Associates, PA* restricts how the individual identifiable health information of the patient named above is used and/or disclosed to carry out treatment, payment, or health operations. I understand that *Pediatric Pulmonary & Allergy Associates, PA* does not have to agree to such restrictions, but that once such restrictions are agreed to, *Pediatric Pulmonary & Allergy Associates, PA* must adhere to such restrictions.

I, _____ as the parent/legal guardian of
Parent/Legal Guardian

_____
Patient Name

have power to consent to the medical care of the child named above. In my absence, the following people are authorized to accompany and/or consent to the medical care or treatment of my child.

_____ Relationship to child: _____
Print Name of Individual other than parent

_____ Relationship to child: _____
Print Name of Individual other than parent

I understand that *Pediatric Pulmonary & Allergy Associates, PA* will not render services to the child named herein if any other person other than those listed above accompanies him/her.

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

_____ _____
Printed Name of Parent/Legal Guardian **Relationship to Patient**

Medical Questionnaire – New Patient Work-Up Sheet

Today's Date: _____ /_____ /_____

Patient's Name: _____ DOB: _____ /_____ /_____

Chief Complaint (Reason for visit): _____

Accompanied by: _____ Relation: _____

Pediatrician's Name:_____ Phone: _____

Pharmacy Name: _____ Phone: _____

Is your child on any medications? ☐Yes ☐No (if yes, please list below)

Do we have your consent to pull prescription history from the pharmacy data base? ☐Yes ☐No

Name of Medication _____ Dosage _____ Frequency _____

Name of Medication _____ Dosage _____ Frequency _____

Name of Medication _____ Dosage _____ Frequency _____

Is your child allergic to any medications? ☐Yes ☐No (if yes, please list below)

Allergic to: _____

Past Medical History

X-Rays or Scan? ☐Yes ☐No Facility: _____

Recent Blood Work? ☐Yes ☐No Facility: _____

Any Hospitalizations? ☐Yes ☐No Facility: _____ Reason: _____

Any Surgeries? ☐Yes ☐No Facility: _____ Reason: _____

Immunizations up to date? ☐Yes ☐No

Family History

Has anyone in the family (mother/father, sister/brother, grand-parents, aunt/uncle) had any of the following:

Environmental Allergies:	☐ Yes	☐ No	Whom: _____
Cancer:	☐ Yes	☐ No	Whom: _____
Blood/Bruising/Bleeding disorders:	☐ Yes	☐ No	Whom: _____
Diabetes/Endocrine Problems:	☐ Yes	☐ No	Whom: _____
Neuro Problems/Stroke:	☐ Yes	☐ No	Whom: _____
Heart Disease:	☐ Yes	☐ No	Whom: _____
Hypertension:	☐ Yes	☐ No	Whom: _____
Lung Disorders/Asthma:	☐ Yes	☐ No	Whom: _____
GI Problems:	☐ Yes	☐ No	Whom: _____
Lipid disorders:	☐ Yes	☐ No	Whom: _____
Skin disorders:	☐ Yes	☐ No	Whom: _____

Social History

Please answer **yes** or **no** to the following questions:

Attends Daycare/School: ☐ Yes ☐ No

Children in household: ☐ Yes ☐ No

Tobacco smoke exposure: ☐ Yes ☐ No

Pets in household: ☐ Yes ☐ No

Cat☐ Dog☐ Other _____

Review of Systems

☐ **Follow Up Visit - No changes since last visit**

Please check off any symptoms that your child **currently** has

CONSTITUTIONAL
- ☐ Good general health lately
- ☐ Weight loss
- ☐ Night sweats
- ☐ Fever
- ☐ Weight gain
- ☐ Headaches
- ☐ Chills
- ☐ Fatigue
- ☐ Malaise
- ☐ Bruises Easily
- ☐ Swollen Glands

HEAD/EYES
- ☐ Blurred vision
- ☐ Discomfort to light
- ☐ Eye discharge
- ☐ Vertigo
- ☐ Vision change
- ☐ Wear glasses or contacts
- ☐ Lightheadedness
- ☐ Double vision
- ☐ Glaucoma
- ☐ Tearing
- ☐ Eye Pain
- ☐ Blind Spots

EARS/NOSE/THROAT
- ☐ Earaches or drainage
- ☐ Colds
- ☐ Snoring
- ☐ Nose bleeding
- ☐ Hoarse voice
- ☐ Thyroid mass
- ☐ Sinus pains
- ☐ Nasal congestion
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Chronic sinus problem or rhinitis
- ☐ Nasal discharge

ALLERGIC / IMMUNOLOGIC /SKIN
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Salty taste
- ☐ Pigmentation
- ☐ Dry skin
- ☐ Eczema

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Dyspnea on exertion
- ☐ Heart murmurs
- ☐ Phlebitis
- ☐ Palpitations
- ☐ Edema
- ☐ Vascular Claudication
- ☐ Swelling of feet, ankles, or hands
- ☐ Syncope
- ☐ Nocturnal paroxysmal dyspnea
- ☐ Hypertension
- ☐ Orthopnea
- ☐ Cyanosis
- ☐ Varicosities

MUSCULOSKELETAL
- ☐ Pain
- ☐ Weakness
- ☐ Muscle pain or cramps
- ☐ Stiffness/swelling
- ☐ Muscle atrophy
- ☐ Cold extremities
- ☐ Joint swelling
- ☐ Night cramps
- ☐ Joint pain
- ☐ Back pain

RESPIRATORY
- ☐ Cough
- ☐ Coughing up blood
- ☐ Dry cough
- ☐ Shortness of breath
- ☐ Recurring infections
- ☐ Wheezing
- ☐ Asthma
- ☐ Stridor
- ☐ Tuberculosis
- ☐ Anaphylaxis

NEUROLOGIC
- ☐ Seizures
- ☐ Paresthesia
- ☐ Headaches
- ☐ Developmental delay
- ☐ Fainting
- ☐ Difficulty with speech
- ☐ Dizziness
- ☐ Incoordination
- ☐ Sensory of motor disturbances
- ☐ Head injury
- ☐ Difficulty walking
- ☐ Tremor
- ☐ Ataxia
- ☐ Stroke

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Oily stool
- ☐ Diarrhea
- ☐ Jaundice
- ☐ Abnormal stools
- ☐ Flatulence
- ☐ Vomiting
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Rectal bleeding or blood in stool
- ☐ Recent changes in bowel habits
- ☐ Indigestion
- ☐ Heartburn
- ☐ Constipation
- ☐ Peptic ulcer

PSYCHIATRIC
- ☐ Depression
- ☐ Memory loss or confusion
- ☐ Visual hallucinations
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Audio Hallucinations
- ☐ Suicidal thoughts
- ☐ Anorexia nervosa
- ☐ Previous psychiatric care
- ☐ Anxiety
- ☐ Bulimia
- ☐ Bipolar

ENDOCRINE
- ☐ Excess thirst
- ☐ Heat intolerance
- ☐ Skin becoming dryer
- ☐ Cold intolerance
- ☐ Polyphagia
- ☐ Weight changes
- ☐ Goiter
- ☐ Glandular or hormone problem
- ☐ Polyuria
- ☐ Diabetes
- ☐ Polydipsia

Patient Name: _____ DOB: _____

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Office Policies

1. **Referrals**
   Our staff kindly makes every effort to remind you to obtain a referral for your appointment. However, it is the parent's responsibility to have the proper referral at the time of the appointment.

2. **Prescription refills**
   Medication refills will not be processed if your child has either not been seen in the last 6 months or has missed their last appointment.

3. **Appointment Policy**
   As a courtesy to our patients, we will attempt to confirm appointments 24-48 hours before their scheduled time. Once an appointment is made that time is reserved for your child. A fee of **$35.00** will be charged to your account for "no-show" appointments without prior notification 24 hours in advance. This fee will need to be paid prior to your next appointment. Patients that arrive over 15 minutes late will need to wait until all the scheduled appointments have been seen first.

4. **Appointments for test results**
   In an effort to provide the best quality care for your child, a follow up appointment may be necessary following a test that your physician ordered in order to document the results and forward a consultation report to your primary care physician. **Please be aware that results will not be given over the phone.**

5. **Request for medical records by email or fax**
   You will be financially responsible for the following fees: **$1.00 each page for the first 25 pages, then .25¢ for each page thereafter.** Medical records will take approximately 5-7 business days to be forwarded.

6. **Messages via Voicemail**
   It is important that you do not leave messages regarding emergency situations on our voicemail. All urgent matters should be discussed with a live staff member so that it can be directed properly.

7. **Communications via Email**
   Email is not available for communications regarding patient care, prescriptions, request for records etc. Kindly call our office so that one of our staff members may assist you and forward your request to the appropriate department.

☐ I hereby acknowledge that I have reviewed and received a copy of Pediatric Pulmonary & Allergy Associates office policies.

_____ **Date:** _____ / _____ /_____

Signature of Parent/Legal Guardian