Tracey Burton-Lindner M.D.
Pediatrics of Okaloosa

850-678-9009
Fax: 850-678-3444

www.pediatricsofokaloosa.com

1001 W. College Blvd, Suite C, Niceville, FL 32578

Patient Information (Confidential) **Date**: _____

Name: _____ - _____
Last First Middle Preferred to be called

DOB: ____/____/____ ☐ M ☐ F Best Email address: _____

Primary Address: _____ **City:**_____ **St:**_____ **Zip:**_____

Primary Phone: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work Landline/Cell/Work

Child lives with: ☐ Both Parents ☐ Mom ☐ Dad ☐ other

Medical Guardian/authorization for medical Information: ☐ Both Parents ☐ Mom ☐ Dad ☐ other

Please define other: _____

Mother: _____ DOB: ____/____/____

Address: _____ **City:**_____ **St:**_____ **Zip:**_____

☐ Same as primary address

Primary Phone: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work Landline/Cell/Work

Father: _____ DOB: ____/____/____

Address: _____ **City:**_____ **St:**_____ **Zip:**_____

☐ Same as primary address

Primary Phone: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work Landline/Cell/Work

Guardian: _____ DOB: ____/____/____
Relationship to patient

Address: _____ **City:**_____ **St:**_____ **Zip:**_____

☐ Same as primary address

Primary Phone: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work Landline/Cell/Work

Emergency Contact: _____ - _____
Phone

Insurance Information:

Company/Plan name: _____ Insured ID#_____ Eff Date: _____

Insured Members name: _____ Relationship to Pt: _____

Name of Employer:_____ Group#_____

It is **YOUR** responsibility to know your insurance benefits. As a courtesy, Pediatrics of Okaloosa will attempt to verify your health insurance benefits, and or necessary authorizations for you. Please be aware, this is only "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. I give Pediatrics of Okaloosa permission to file claims with the above insurance company on my behalf.

Signature: _____ Date: _____

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New Patient Health Questionnaire

Name: _____ Date _____

DOB: _____ ☐ M ☐ F

Form completed by/Relationship _____

Household
Please list all those living in the home with your child

Name	Relationship to child	DOB	Health Issues - list

Are there siblings not listed? If so, please list names, ages & where they live. _____

Child lives with – if not with both biological parents:

☐ Mom ☐ Dad ☐ Joint custody ☐ single custody ☐ Adoptive Parents ☐ Foster Family

If one or both parents are not living in the home, how often does the child see the parents) not in the home? _____

Birth History
☐ Don't know birth history

Birth weight _____ Was baby term?_____ **Or** _____ # Weeks

Prenatal or neonatal complications? ☐ No ☐ Yes – explain:

_____

NICU stay: ☐ No ☐ Yes – Explain: _____

Delivery: ☐ Vaginal ☐ Cesarean- why_____

Initial Feeding: ☐ Formula ☐ Breastfed – how long _____

Did baby go home with mother from hospital? ☐ Yes ☐ No – Explain: _____

During pregnancy, did mother-

☐ Take Pre-natal vitamins ☐ Prescription Medications: What & When _____

☐ Use drugs: _____ What & When _____ ☐ Use tobacco ☐ Drink alcohol

General: DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ DK ☐ No: Explain: _____

Does your child have any serious illness or medical conditions? ☐ No ☐ DK ☐ Yes – explain: _____

Surgery: ☐ None ☐ DK ☐ Yes-explain: _____

Hospitalizations: ☐ None ☐ DK ☐ Yes – explain: _____

Allergies to medications/drugs: ☐ None ☐ DK ☐ Yes – explain: _____

Do you feel your family has enough to eat? ☐ Yes ☐ DK ☐ No-explain: _____

Does your child have or ever had:				Explain
Chicken Pox	☐ No	☐ DK	☐ Yes	When: _____
Frequent ear infections	☐ No	☐ DK	☐ Yes	_____
Problems with ears or hearing	☐ No	☐ DK	☐ Yes	_____
Problems with eyes or vision	☐ No	☐ DK	☐ Yes	_____
Nasal Allergies	☐ No	☐ DK	☐ Yes	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ No	☐ DK	☐ Yes	_____
Heart problems or Heart murmur	☐ No	☐ DK	☐ Yes	_____
Anemia or Bleeding disorder	☐ No	☐ DK	☐ Yes	_____
Received Blood transfusions	☐ No	☐ DK	☐ Yes	_____
HIV	☐ No	☐ DK	☐ Yes	_____
Cancer, Malignancy/ Bone Marrow Transplant	☐ No	☐ DK	☐ Yes	_____
Chemotherapy	☐ No	☐ DK	☐ Yes	_____
Organ Transplant	☐ No	☐ DK	☐ Yes	_____
Kidney disease or urologic malformations	☐ No	☐ DK	☐ Yes	_____
Bed-wetting after age 5	☐ No	☐ DK	☐ Yes	_____
Recurrent Urinary tract infections & problems	☐ No	☐ DK	☐ Yes	_____
Frequent Abdominal pain	☐ No	☐ DK	☐ Yes	_____
Constipation requiring doctor visits	☐ No	☐ DK	☐ Yes	_____
Metobolic/Genetic disorders	☐ No	☐ DK	☐ Yes	_____
Congenital cataracts/retinoblastoma	☐ No	☐ DK	☐ Yes	_____
Developmental delay or disability	☐ No	☐ DK	☐ Yes	_____
Sleep problems - Snoring	☐ No	☐ DK	☐ Yes	_____
Chronic or recurrent skin issues – eg: acne/eczema	☐ No	☐ DK	☐ Yes	_____
Frequent Headaches	☐ No	☐ DK	☐ Yes	_____
Convulsions or other neurologic problems	☐ No	☐ DK	☐ Yes	_____
Obesity	☐ No	☐ DK	☐ Yes	_____
Diabetes	☐ No	☐ DK	☐ Yes	_____
Thyroid or Endocrine issues	☐ No	☐ DK	☐ Yes	_____
High Blood Pressure	☐ No	☐ DK	☐ Yes	_____
History of serious injuries/fractures, concussions	☐ No	☐ DK	☐ Yes	_____
Use of Alcohol, Drugs, Tobacco	☐ No	☐ DK	☐ Yes	_____
ADHD/anxiety/mood problems/depression	☐ No	☐ DK	☐ Yes	_____
Dental Decay	☐ No	☐ DK	☐ Yes	_____
History of family violence	☐ No	☐ DK	☐ Yes	_____
Sexually transmitted infections	☐ No	☐ DK	☐ Yes	_____
For Girls: Has had first period	☐ No	☐ DK	☐ Yes	_____
Problems with periods	☐ No	☐ DK	☐ Yes	_____
Pregnancy	☐ No	☐ DK	☐ Yes	_____
Any other significant problems?	_____			

Biological Family History

Any family members with the following?				Who	Comments
Childhood hearing loss	☐ No	☐ DK	☐ Yes		
Nasal Allergies	☐ No	☐ DK	☐ Yes		
Asthma	☐ No	☐ DK	☐ Yes		
Tuberculosis	☐ No	☐ DK	☐ Yes		
Heart Disease before age 55	☐ No	☐ DK	☐ Yes		
High Cholesterol- on medication	☐ No	☐ DK	☐ Yes		
Anemia	☐ No	☐ DK	☐ Yes		
Bleeding disorder	☐ No	☐ DK	☐ Yes		
Dental Decay	☐ No	☐ DK	☐ Yes		
Cancer – before age 55	☐ No	☐ DK	☐ Yes		
Liver disease	☐ No	☐ DK	☐ Yes		
Kidney disease	☐ No	☐ DK	☐ Yes		
Diabetes – before age 55	☐ No	☐ DK	☐ Yes		
Bed-wetting after age 10	☐ No	☐ DK	☐ Yes		
Obesity	☐ No	☐ DK	☐ Yes		
Epilepsy or convulsions	☐ No	☐ DK	☐ Yes		
Alcohol abuse	☐ No	☐ DK	☐ Yes		
Drug abuse	☐ No	☐ DK	☐ Yes		
Mental Illness/depression	☐ No	☐ DK	☐ Yes		
Developmental disability	☐ No	☐ DK	☐ Yes		
Immune problems, HIV or AIDS	☐ No	☐ DK	☐ Yes		
Tobacco Use	☐ No	☐ DK	☐ Yes		
Additional Family history	☐ No	☐ DK	☐ Yes		

If there are multiple children in a family- copy page three and only complete one time.

This New Patient Health Questionnaire is consistent with American Academy of Pediatrics & Bright Futures: Guidelines for Health Supervision of Infants, Children & Adolescents.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ Phone #: _____

I hereby authorize _____
Physician Name/Hospital Name/Clinic Name

to release the following information from ☐ My records (over 18yrs) ☐ My child's (under 18yrs)

medical records ☐ during the period _____ to _____

☐ all records

to include: ☐ Medical transcripts/notes ☐ Lab reports ☐ X-Ray reports

Release records to: ☐ Pediatrics of Okaloosa, 1001 West College Blvd, Suite C, Niceville FL 32578
Fax: **850-678-3444**

or to: ☐ _____
Name & address of medical office

_____-_____
Fax Number Phone Number

I acknowledge and agree that I have read (or had someone read to me) the following statements:

- This authorization expires in 12 months from the date signed unless an alternative date, event, or "no expiration designated" is inserted here: _____ No further disclosures described above may be made after the expiration.
- I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnosed & therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
- I may refuse to sign this authorization and that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke my consent at any time by submitting my revocation request in writing. The revocation of this request will not affect any health information disclosed prior to Pediatrics of Okaloosa receiving my written notice.
- I understand that information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations.
- I understand that I have a right to see & obtain a copy of the information described on this form, and/or a copy of this form for a reasonable copy fee, if I ask.

****

*By signing, I understand that I am authorizing Pediatrics of Okaloosa to **release/obtain** information as described above. I hereby release Pediatrics of Okaloosa – Tracey Burton – Lindner & (associates, employees, medical staff members and agents) from any and all claims, liability, suits or costs related to the use of images or disclosure of the information and materials described herein*

_____ _____ _____
Signature – must be signed by patient if over 18 yrs of age | Date | Authority to act on behalf of patient (attach document)

If greater than ten (10) pages please mail records to the address above

Pediatrics of Okaloosa P.A.

Tracey Burton Lindner, M. D.
1001 West College Blvd., Suite C - Niceville, Florida

Name: _____

Date of Birth: _____

Consent for treatment *and to the*
Use & Disclosure of Health Information for Treatment, Payment, or Healthcare Operation

Consent to Treat:

I am the parent or legal guardian for the patient listed above and I authorize Pediatric of Okaloosa to evaluate and treat and to release to the insurance company any information acquired in the course of their examination or treatment, and to receive all payments for such examination or treatment, Pediatric of Okaloosa has my permission to release any diagnostic studies, reports, etc. to a specialist involved in their care._____initial

I understand that as a part of **my child's** healthcare, Pediatrics of Okaloosa, will originate and maintain health records that describe my child's history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment.

I understand that these health records serve as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to my child's care
- A source of information for applying my child's diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- *We will file your claim with your insurance as a courtesy, all claims unpaid after 60 days become the responsibility of the patient to be paid in full.* _____initial

I understand and have been provided/offered a copy of the Notice of Information and privacy practices which provides a more complete description of information uses and disclosures. I understand that Pediatrics of Okaloosa reserves the right to change its notices and practices. If changes are made Pediatrics of Okaloosa will notify me. I may request restrictions in writing. I understand and accept the above information.

_____ _____ _____ _____
Signature-Mother-Father-Guardian (Circle one) Date Home Phone Cell Phone
☐ Primarily responsible for medical decisions ☐ Authorized to make medical decisions

_____ _____ _____ _____
Signature-Mother-Father-Guardian (Circle one) Date Home Phone Cell Phone
☐ Primarily responsible for medical decisions ☐ Authorized to make medical decisions

Pediatrics of Okaloosa P.A.

Tracey Burton Lindner, M. D.
1001 West College Blvd., Suite C - Niceville, Florida

Name: _____

Date of Birth: _____

Consent for treatment and to the
Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operation

I authorize Pediatric of Okaloosa to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment, Pediatric of Okaloosa has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care. _____Initial

I understand that as part of **my healthcare**, Pediatrics of Okaloosa, originates and maintains health records that describe my history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment. I understand that these health records serve as:

I understand that these health records serve as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- *We will file your claim with your insurance as a courtesy; all claims unpaid after 60 days become the responsibility of the patient to be paid in full.* _____initial

I understand and have been provided/offered a copy of the Notice of Information and privacy practices which provides a more complete description of information uses and disclosures. I understand that Pediatrics of Okaloosa reserves the right to change its notices and practices. If changes are made Pediatrics of Okaloosa will notify me. I may request restrictions in writing. I understand and accept the above information.

_____	_____	_____	_____
Signature	Date	Home Phone	Cell Phone

Parents can be called ☐ (Y) ☐ (N)

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Consent to Treat Patient – Without Parent /Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minors Name: _____ DOB: _____
(Last, First, Middle)

Allergies:_____

Current Medications:_____

Chronic Conditions:_____

This consent applies to:

- ☐ complete physician check-up
- ☐ vision, scoliosis, and blood pressure screening
- ☐ immunizations
- ☐ first aid and emergency care
- ☐ prescription and treatment for illness
- ☐ referrals to an outside agency (for example: hospital, radiology) for services not provided at the office
- ☐ laboratory work. (including blood and urine samples, throat cultures, other deemed necessary)
- ☐ Other: _____

If there are any services that you do not consent to in your absence, please list: _____

_____

For those occasions when I may not be with my child, he/she will be accompanied by:

☐ Themselves – (must be 16 years or older)

☐ Name: _____ Relationship: _____

I give permission for the physician to share any relevant health information with the person who is accompanying my child: From (todays date):_____Until:_____.

(may not be longer than 1 year and may be revoked in writing anytime).

_____ _____

Parent or Guardian Signature | Parent or Guardian Name (Please Print)

Phone Consent obtained - Date Obtained: _____

☐ _____ _____

Witness | Witness

Best phone number to reach parent should we need to speak to a parent during the appointment

_____ Home/work/cell ☐ Mother ☐ Father

_____ Home/work/cell ☐ Mother ☐ Father