Patient's Name: _____ DOB: _____

M ____ F ____ Age: _____ Acct #: _____

Mother's Age: _____ Health: _____ M ___ D ___ S ___ Other _____

Father's Age: _____ Health: _____ M ___ D ___ S ___ Other _____

List Name, Age, and Sex of all Siblings: _____

List anyone else living at home with this child: _____

Please check any of the problems listed below that are present in any family member, include the child's parents, grandparents, aunts, uncles, and cousins.

AIDS (pos. HIV test) _____
Allergies _____
Anemia _____
Asthma _____
Bleeding Problems _____
Cancer / Leukemia _____
Crib Death (SIDS) _____
Depression _____
Diabetes _____
Drug / Alcohol Problems _____
Early Deafness _____
Eczema _____
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Kidney Problems _____
Inherited Disorders _____
Lazy Eye _____
Lupus _____
Mental Illness _____
Migraines _____
Psychiatric Problems _____
Rheumatoid Arthritis _____
Seizures / Epilepsy _____
Sickle Cell Anemia (or Trait) _____
Sinus Problems _____
Tuberculosis _____
Other _____

FAMILY HISTORY **DATE COMPLETED** _____ **DATE(s) REVISED** _____

Lillian Reguero, M.D.
Pediatrics & Adolescent Medicine

94 West Underwood Street, Orlando, FL 32806
(407) 422-8873 tel • (407) 425-4294 fax

PATIENT INFORMATION

Date: _____ Acct # _____

Patient's Name _____ Sex: M ____ F____

Address: _____

City: _____ State: _____ Zip: _____ Home Ph: (___) _____

Date of Birth: _____ Cell Ph: (___) _____

Father:

Name: _____ M ___ S ___ D ___ Re-Married ___ Deceased ___

Address: _____

City: _____ State: ____ Zip: _____ Phone #: (____) _____

S.S. #: ____ /____ /_____ Driver's License #: _____

Employer: _____ Position: _____ How Long Employed? _____

Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

Mother:

Name: _____ M ___ S ___ D ___ Re-Married ___ Deceased ___

Address: _____

City: _____ State: ____ Zip: _____ Phone #: (____) _____

S.S. #: ____ /____ /_____ Driver's License #: _____

Employer: _____ Position: _____ How Long Employed? _____

Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

Authorization:

I authorize the release of any medical or other information necessary to process insurance claims. I request and authorize payment of medical benefits to Lillian Reguero, MD, PA for services rendered. I understand that this signature is a lifetime signature.

_____ _____ (over Please)

(Signature of Parent or Legal Guardian) Date

Who may I thank for referring you to my practice?

_____ Friend / Family Member: Name _____

_____ Physician / Nurse: Name _____

_____ Yellow Pages

_____ Company Medical Plan / Insurance Book

_____ Recommended by Hospital

_____ Other _____

Insurance Information:

Insurance Company Name: _____

Policy Holder: _____

Contract #: _____

Group #: _____

Address To File Claim:

_____

_____

_____

Phone #: (_____) _____

HMO _____ PPO _____ Traditional _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes on the above information.

_____ _____

(Signature) (Date)

How do you expect to pay? Cash _____ Check _____ Credit Card _____

Prompt payment for office visit and procedures is appreciated.

Lillian Reguero, M.D.
Pediatrics & Adolescent Medicine

94 West Underwood Street
Orlando, Florida 32806

(407) 422-8873 tel
(407) 425-4294 fax

Dear Parent,

Welcome and thank you for choosing me to provide your child's medical care. It is my goal to provide personalized, quality healthcare, and to build a professional relationship based on open communication, trust, mutual respect, and education. As a pediatrician, I have received specialized training in the health care of infants, children, and adolescents and am able to care for your child's changing healthcare needs throughout his/her growing years.

To assist you in becoming familiar with my office and its policies, PLEASE READ THIS LETTER CAREFULLY.

Office visits are by appointment only to allow scheduled patients to be seen in a timely manner. When scheduling regular physical exams, please do so three to four weeks in advance. Your appointment time is yours exclusively with me and I have reserved this time for you.

Please call early in the day if your child is sick and may need an appointment. If your appointment must be canceled for any reason, please call with at least 48 hours notice. This will allow us to see other children who may be ill. You may be charged for appointments canceled without 48 hours notice. We understand that there are times when a notice is not possible and these situations will be handled on a case-by-case basis.

Office Hours: My office hours are Monday through Friday, 9:00 a.m. to 5:00 p.m.

Appointment Hours: Monday, Tuesday, and Thursday mornings from 8:30 a.m. to 12:30 p.m. My nurse will be available to answer questions and handle prescriptions and refills Monday through Friday from 8:30 a.m. to 4:30 p.m. **You must allow at least 1 full business day advance notice for prescriptions and refills.** After office hours, phone calls will be billed to you and not your insurance at the discretion of the nurse and/or physician. (Fees vary from $15 to $75.)

Education: At your first office visit, parents of newborns are given a special booklet, which will help you as a parent to become somewhat self-sufficient in your child's health care. Please read this booklet carefully and refer to it often regarding your child's medical needs through the newborn period.

Emergencies: If you feel you have a true emergency that cannot wait for my regular office hours, please take your child to an emergency room or urgent care center. I will be available for follow-up care during office hours. In the event your child needs to be hospitalized during non-office hours, there is always a pediatrician on-call at each hospital.

Payment Policy: Charges, which may include professional fees and laboratory charges, are due and payable at the time of your child's visit. For your convenience, we accept payment by MasterCard, Visa, Discover, personal check, cash, or money order. Our statement furnished prior to your leaving the office is designed to itemize all charges, document your payment, and provide proof of your claim for reimbursement for patients who file to their insurance carrier themselves. If your carrier requires further documentation, we will be happy to assist you.

For my patients covered by an insurance carrier with which I am contracted, the procedure varies. You must produce a valid I.D. card documenting your membership in the specific group insurance plan. My office will bill your carrier directly for covered services.

OVER PLEASE

- My office will collect your deductible, copay, uncovered services, or percentage due at the time of your visit. Please be prepared to pay before you are seen.

- Please be thorough with your insurance information if you expect the office to file for you. Bring your insurance card with you and any authorization information you may have. You will be responsible for any unpaid balances due to lack of information. Any balance over 30 days will accrue interest at a rate of 1.5% per month.

- As a courtesy, my office will file your insurance. It is your responsibility to make sure we receive prompt payment from them. It is helpful to maintain frequent contact with your insurance carrier to make sure they are paying correctly, as this will decrease your balance due to us. We allow 2 months for your insurance company to pay on filed claims. If there are any problems receiving payments from your insurance company, it is expected that you agree to actively and vigorously pursue collecting the insurance payment for this office.

- Payment for all charges is in accordance with the provisions outlined in the previous paragraph. In the event that collection of your account becomes necessary, you will be responsible for interest, attorney fees, and all other costs of collection efforts.

- If your insurance company denies payment on your account, you will be asked to pay by check, cash, MasterCard, Visa, or Discover. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge consistent with the maximum amount allowable by law.

- I understand that I am responsible for any amount not covered by my insurance. I assign all payments for medical services rendered to my son/daughter to Lillian Reguero, M.D.

- I hereby authorize Lillian Reguero, M.D. to release any part of my son's/daughter's medical record and information to insurance carriers concerning his/her illness and treatments.

- My office does not accept Medicaid as payment. If for any reason you apply for this coverage with or without our knowledge, your bill becomes due immediately. With prior arrangements, we will assist you in collecting from these agencies. Nevertheless, the charges are your responsibility.

SELF-PAY PATIENTS: This category includes those patients with no insurance and those patients who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the service is rendered. My office accepts Visa, MasterCard, Discover, Checks, Cash, and Money Orders. If you will not be able to pay the amount due at time of service, you must contact my office to make a payment agreement with the business office before coming to see me. If you have no agreement with my office, payment in full will be expected.

As a final note: I apologize for any inconvenience that these necessary guidelines may cause you. My practice is not the cause of insurance delays and denials. We file to insurance companies expeditiously on a daily basis.

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, not to us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims. By law, they must supply you with this information. If you have any questions regarding any of these policies, please call my office before I see you.

Again, thank you for your confidence in choosing me to provide pediatric care for your child(ren). I look forward to caring for your child(ren) throughout his/her growing years.

Sincerely,
Lillian Reguero, M.D.

I have read and understand the above letter and I agree with the policies outlined. I also understand that this is a lifetime signature.

Signature of Parent or Legal Guardian _____ Date _____

EMOTIONAL:

		Yes	No
1.	Is your child having problems in school?	☐	☐
2.	Does your child have trouble getting along with other children?	☐	☐
3.	Does your child have problems with thumb sucking or nail biting?	☐	☐
	Breath holding?	☐	☐
4.	Does your child stutter or have other speech problems?	☐	☐

OTHER:

1.	Has your child had DPT vaccine?	☐	☐
	How many?_____		
2.	Has your child had Polio vaccine?	☐	☐
	How many?_____		
3.	Has your child had MMR?	☐	☐
4.	Has your child had HIB vaccine?	☐	☐
	How many?_____		
5.	Did your child receive a skin test for Tuberculosis?	☐	☐
6.	Did your child receive a Hepatitis B vaccine?	☐	☐
	How many?_____		
7.	Did your child receive a Chickenpox vaccine?	☐	☐

Medical history is to be completed by mother or responsible parent.

Patient's Name: _____ DOB: _____ M___ F___

PREGNANCY AND BIRTH:

		Yes	No
1.	Did you have any illnesses or other complications during your pregnancy?	☐	☐
2.	Did you deliver your child too early?	☐	☐
3.	Did you deliver your child too late?	☐	☐
4.	Did your baby have any trouble starting to breathe?	☐	☐
5.	Did your baby develop any problems while in the hospital?	☐	☐
	Baby's Weight _____ Apgar Scores _____		

FEEDING:

1.	Did your baby have colic or any feeding problems in the first 3 months?	☐	☐
2.	Is your child a problem eater now?	☐	☐
3.	Have any foods disagreed with your child?	☐	☐
4.	Does your child have diarrhea?	☐	☐
5.	Does your child have a problem with constipation?	☐	☐
6.	Does your child take vitamins? What brand?_____	☐	☐
7.	Does your child take Fluoride?	☐	☐
8.	What formula did you feed your child as an infant? _____		

INFECTIONS, ILLNESSES AND MISCELLANEOUS PROBLEMS:

		Yes	No
1.	Has your child had ear infections?	☐	☐
	How many?_____		
2.	Has your child had bronchitis or pneumonia?	☐	☐
	Wheezing or prolonged cough?	☐	☐
3.	Does your child have frequent colds or sore throats?	☐	☐
4.	Has your child had trouble with urination?	☐	☐
5.	Has your child ever had a convulsion?	☐	☐
6.	Does your child have problems with hearing?	☐	☐
7.	Does your child have problems with vision?	☐	☐
8.	Does your child have any trouble sleeping?	☐	☐
9.	Has your child had any problems with teeth?	☐	☐
10.	Has your child had any overnight hospital stays?	☐	☐

Dates: _____ Reason _____

11.	Has your child had any operations?	☐	☐

Dates: _____ Reason _____

12.	Has your child had any serious accidents?	☐	☐
13.	Has your child had Chicken Pox or any other childhood illness?	☐	☐
14.	Has your child ever been anemic?	☐	☐
15.	Has your child had any other health or emotional problems?	☐	☐

DEVELOPMENT:

1.	Did your child have any delay in developmental milestones?	☐	☐

Please list ages in months the following milestones were attained:

Sitting alone _____ Walking _____ Words _____

2-3 word sentences _____ Toilet Training _____ Pedaling Tricycle _____

ALLERGIES AND IMMUNIZATIONS:

		Yes	No
1.	Has your child ever had eczema, hives, or asthma?	☐	☐
2.	Has your child ever had constant stuffy nose or cold symptoms?	☐	☐
3.	Has your child had reactions to medicines or injections?	☐	☐
4.	Has your child ever had reactions to foods?	☐	☐
5.	Has your child had any reactions to immunizations?	☐	☐
6.	Is your child missing any immunizations necessary for his/her age?	☐	☐

Please provide our office with proof of immunizations, including dates.

Lillian Reguero, M.D., P.A.
Pediatrics & Adolescent Medicine
Board Certified • Fellow of the American Academy of Pediatrics

I, _____ (Parent / Guardian) understand that:

1. It is **my responsibility** to call and schedule any and all tests, consults, or procedures ordered by my child's physician for as along as he/she is her patient and, in some instances, for life. I also understand that it is **my responsibility** to schedule any follow up appointments associated with these tests, consults, or procedures ordered by my physician. I also understand that these tests should be done as soon as possible in order to assure proper medical care for my child. It is also **my responsibility** to choose the hospital or consultants that are contracted with my insurance company. **Failure to comply** with the above could result in inadequate or insufficient medical care and/or additional charges that will not be covered by my insurance.

2. It is **my responsibility** to make sure that Dr. Reguero receives the results of the test(s).

3. **I will hold harmless** Dr. Reguero and/or any other employee of Lillian Reguero, MD, PA from any liability for condition(s) that might develop resulting from my **non-compliance or failure** to act immediately or on a long term basis upon this order for tests, including but not limited to, future tests, follow up appointments, or consults for my child.

4. I understand that I am relinquishing some of my rights as a parent / guardian by not complying with the above instructions. Nevertheless, I understand the above is for the best of my child's care and benefit.

Patient Name: _____

Parent / Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Lillian Reguero, M.D., P.A.
Pediatrics & Adolescent Medicine
Board Certified • Fellow of the American Academy of Pediatrics

Patient Name: _____

Parent / Guardian Name: _____

Insurance Company: _____

My insurance company requires my laboratory services to be sent to:

Please check one:

Quest Diagnostics _____

LabCorp of America _____

LabOne _____

Other (please specify) _____

It is extremely important that your lab work is sent to the correct lab for insurance purposes. Lillian Reguero, MD, PA staff will not be responsible for any labs sent to the wrong location. You will be held responsible for any lab costs incurred.

Parent / Guardian Signature: _____ Date: _____

THE PERINATAL CENTER P.A.

OLIVER K. BAYOUTH, M.D.

LILLIAN REGUERO, M.D., F.A.A.P.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient: _____

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details.

_____

_____

_____

_____ _____

Employee Signature *Date*