

# Pediatric Health History Form

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_  
CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: \_\_\_\_\_  
PRESENT HEALTH CONCERNS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICINE/VITAMINS:** \_\_\_\_\_  
**HERBS/HOME REMEDIES:** \_\_\_\_\_  
**ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS:** \_\_\_\_\_

**PREGNANCY & BIRTH:**  
Where was your child born? \_\_\_\_\_  
Is the child yours by:  Birth  Adoption  Stepchild  Other: \_\_\_\_\_  
Medical problems during pregnancy:  None  Yes, Specify: \_\_\_\_\_  
Delivered by:  Vaginal birth  Caesarean If Caesarean, why? \_\_\_\_\_  
Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR score: 1 min \_\_\_\_\_ 5 min \_\_\_\_\_  
Please indicate any medical problems during baby's newborn period \_\_\_\_\_  
premature, how early? \_\_\_\_\_ Other problems: \_\_\_\_\_

**NUTRITION & FEEDING:**  
Was your child breastfed?  No  Yes If so how long? \_\_\_\_\_  
Has your child had any unusual feeding/dietary problems?  No  Yes  
If yes, specify: \_\_\_\_\_  
Milk intake: \_\_\_\_\_ Cow ( Non-fat  2% fat  Whole milk)  Soy  Rice  Other  
Average ounces per day: \_\_\_\_\_ (Note: 8 ounces = 1 cup)

**SLEEP:**  
Hours per night: \_\_\_\_\_ Naps (number & length): \_\_\_\_\_  
Any sleep problems? \_\_\_\_\_

**DEVELOPMENT:**  
At what age did your child:  
Sit alone: \_\_\_\_\_ Walk Alone: \_\_\_\_\_ Speak: \_\_\_\_\_ Toilet train (daytime): \_\_\_\_\_  
Girls only: Age at first menstrual period: \_\_\_\_\_

**DENTAL HISTORY:**  
Has child been seen by a dentist?  No  Yes If so, how often? \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**IMMUNIZATIONS/INFECTIOUS DISEASES:**  
Please bring your child's immunization records to your appointment.  
Has your child had:  
 Chickenpox  Measles  Mumps  Rubella  Meningitis  Tuberculosis

**EXPOSURES/HABITS:**  
Any concerns about lead exposure? (old home/plumbing/peeling paint)  No  Yes  
Do any household members smoke?  No  Yes  
TV: hours/day \_\_\_\_\_ Computer: hours/day \_\_\_\_\_ Video games: hours/day \_\_\_\_\_

**PAST MEDICAL HISTORY:**  
Please describe any major medical problems and dates:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/Operations & Dates: \_\_\_\_\_  
\_\_\_\_\_  
Broken bones or severe sprains: \_\_\_\_\_

**FAMILY HISTORY:**

Please indicate with a check any family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
Autoimmune Disorder												
Bleeding Problem												
Cancer, Breast												
Cancer, Melanoma												
Cancer, Ovary												
Congenital Anomaly/Birth												
Heart Attack/Heart												
Depression												
Diabetes, on insulin												
Diabetes, not on insulin												
Eczema												
Food Allergy												
Genetic Disorder												
Hay Fever												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Mental Retardation												
Stroke												
Substance Abuse												
Thyroid Disorders												
Tobacco Use												
Tuberculosis												
Death before age 56												
Other:												

Other: \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY:**

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents:  Married  Unmarried  Separated  Divorced

If divorced/separated, when? \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Mother's employer \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Father's employer \_\_\_\_\_

Child care situation:  Parents  Others (specify who & hours/day) \_\_\_\_\_

Concerns about your child: Alcohol:  Tobacco:  Sexual activity:  Aggression:

Is violence in the home a concern?  No  Yes

Any concerns about bullying (social)(school) other?  No  Yes

Are there guns in the home?  No  Yes

**SCHOOL HISTORY:**

Did/does your child attend school or preschool?  No  Yes

Current grade: \_\_\_\_\_ Name of school: \_\_\_\_\_

Concerns about school performance? \_\_\_\_\_

Concerns about relationships with Teachers:  No  Yes Students:  No  Yes

If more than 4 years old, does your child have a best friend?  No  Yes  N/A

**Sports/exercise:**

Type: \_\_\_\_\_

How often? \_\_\_\_\_ How long (minutes)? \_\_\_\_\_

**Section I: Patient Information**

Date: \_\_\_\_\_  
Name: First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last: \_\_\_\_\_  
I prefer to be called: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Best time to call: \_\_\_\_\_ AM \_\_\_\_\_ PM on my \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell  
E-Mail address: \_\_\_\_\_

**Check appropriate:**

\_\_\_\_\_ Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

If Student, name of school: \_\_\_\_\_

City/State: \_\_\_\_\_ FT \_\_\_\_\_ PT \_\_\_\_\_

Spouse/Parent's Name: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**The following information must be filled out completely.  
Failure to do so may result in a denial from your insurance company.**

**Section II: Responsible Party**

Relationship to patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other

If self, skip to Section III.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Section III: Insurance Information**

Name of Primary Insured: \_\_\_\_\_ DOB: \_\_\_\_\_  
Primary SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Name of Primary Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID#: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Insurance Company Phone Number: \_\_\_\_\_

**Do you have additional insurance? If YES, please complete the following:**

Name of Primary Insured: \_\_\_\_\_ DOB: \_\_\_\_\_  
Primary SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Name of Primary Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID#: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Insurance Company Phone Number: \_\_\_\_\_

**ENCOUNTER NON-COVERED SERVICE WAIVER**

I acknowledge that I will be charged, and agree to pay interest (at a rate no higher than the maximum permitted by law), on any overdue amounts until they are paid in full. If my account is referred for collection, I agree to pay for all costs of collection, including reasonable attorneys' fees and court costs. When an account is referred to a collection agency, the agency fee will be added to the outstanding balance. The agency fee is currently 25% of the outstanding balance. An \$15 collection fee will be added for all accounts turned over for collections. I understand and agree that any overpayments collected by St Luke's Regional Health Care, PLC with regard to any care, treatment, or services provided to me may be applied to any outstanding amounts then due and payable to St Luke's Regional Health Care, PLC for which I am legally responsible.

Parent Name: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Print

Parent/Responsible Party Signature: \_\_\_\_\_

Patients Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**ST LUKE'S REGIONAL HEALTH CARE  
JOSEPH GHALY, M.D.  
PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing signed by you. However, such revocation shall not affect any disclosures we have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient had the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of his/her information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

\_\_\_\_\_ Date

Patient or representative's name (please print)

\_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Patient or representative's signature

**\*\*\* Please list here any person (s) with whom you wish for us to discuss your medical history, appointments and billing matters. \*\*\***

\_\_\_\_\_  
**Name/Relationship to Patient**

\_\_\_\_\_  
**Name/Relationship to Patient**

**St Luke's Regional Health Care, PLC**  
**Joseph Ghaly, MD**  
**6030 S. Florida Avenue, Suite 110 - Lakeland, FL 33813**  
**Phone: 863.644.9800, Fax: 863.644.9822**

Dear New Patient;

Welcome to St Luke's Regional Health Care. Our office policies are designed to ensure that we are able to provide the highest quality of care for our patients. The staff is not responsible for these policies nor are they authorized to change or modify them. Please take the time to read, sign & return at your first visit. A copy will also be provided upon request.

### **Office Policies**

**Office Hours:** Our regular office hours are Monday through Friday 8:00 am to 5:00 PM.

**Medical Appointments:** Appointments should be made to address any new problem or concern especially if it requires a prescription medication. Appointments are also necessary for periodic follow-up of chronic medical problems, such as high blood pressure, diabetes, high cholesterol, etc. This allows us an opportunity to assess the effectiveness of treatment, evaluate for side effects of medication, & monitor lab work if necessary. New patients need to arrive 30 minutes early for the first appointment, so necessary paperwork can be completed. (All other patients need to arrive prior to scheduled appointment times). Arriving on time helps us to stay on schedule & minimize wait time for you as well as other patients.

**Auto Accident Appointments:** Appointments made for auto cases are billed to your auto Insurance only. We do not bill your medical insurance for exhausted benefits or deductibles. Therefore, any medical issues not pertaining to the auto accident will not be discussed at these visits. If you would like to discuss other medical issues (high blood pressure, weight loss, diabetes, etc.), you will need to schedule a separate office visit. The medical office visit will be billed through your medical insurance. Therefore, your health insurance co-pay and deductible will apply. We will do our best to accommodate both visits on the same day.

**Weight Loss Appointments:** St Luke's Weight Loss program. Patients interested should inquire at the front desk for more information. **Patients enrolled in the weight loss program may only discuss weight loss issues. Any other medical concerns will need to be scheduled a separate office visit due to payment and billing differences.** We will do our best to accommodate both visits on the same day.

**Family/Friends:** There are sometimes instances when family members and friends accompany patients to an office visit. Please note that if medical concerns are addressed for an accompanying member (e.g. such as medication refills) an office visit will be charged. The applicable copayment and deductible will also apply. Please respect the other patients' and the doctor's time and schedule an appointment.

Page 1 of 3 – Office policies      **Patient Initials:** \_\_\_\_\_



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**Insurance/Payment:** Patients who have insurance coverage should provide their insurance card at each visit. If there are any changes to your health care coverage, you must notify us in advance of the appointment so that the insurance may be verified prior to the appointment to minimize wait time. Your failure to update your insurance can result in you being responsible for the charges.

Payment is due at time of service. All copays, deductibles & balances (including family member balances) will be collected at the time of each office visit. Amounts not covered by insurance are the patient's responsibility. We accept Visa, MasterCard, Discover & American Express, cash, and Money Orders. **Due to the increase in returned checks, personal checks will no longer be accepted!**

If you have not met your deductible with your insurance carrier, you will be asked to leave a \$125 deposit, (\$200 if new patient) to cover your office visit. Adjustments will be made on your account after your insurance company has paid their portion.

**Medicare Supplement Insurance:** We are a participating provider with Medicare Part B program; and as such, we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the allowable amount) and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% co-pay and your annual deductible are your responsibility according to federal law. Annual deductibles are set by Medicare each year.

**Nonpayment:** Invoices are sent every 30 days. Your prompt payment will assist us in keeping down the cost of healthcare. You acknowledge that you may be charged, and agree that you will pay, interest at a rate no higher than the maximum permitted by law on any overdue amounts until they are paid in full. If your account remains past due, you understand that your account may be referred to a Collection Agency and agree to pay for all costs of collection, including but not limited to, reasonable attorneys' fees and court costs. You understand that any overpayments collected with regard to any care, treatment, or services provided to you may be applied to any outstanding amounts then due and payable for which you are legally responsible. You understand that in the event you (or your family members) have an outstanding balance, you (they) can be discharged from this practice. If this occurs, you understand that you will be notified by regular and/or certified mail that you have 30 days to find alternative care.

**Cancellations:** We require 24 hours' notice if you are canceling your appointment. If you cancel without 24-hour notice or fail to appear, you may be responsible for a \$30 no-show fee. If you were scheduled for an in-house diagnostic such as nerve conduction study, ultrasound, etc., a \$150 no-show fee will be added

**Form Fees:** there will be a fee charged for the completion of forms (disability parking, adoption, FMLA, physical, prescription, etc.). The fee is \$25 for the first page & \$15 for each additional page. This fee must be paid up front at the time the forms are dropped off.

**Lab Forms:** Due to the increase of lost lab slips/forms, a \$2 fee will be issued for a reprint of a lab form.

**Medical Records:** All medical record requests must be submitted in writing. After you sign an authorization of release, we will provide any doctor's office with a copy of your records free of charge. If you or your legal representative needs copies of these records, we will provide them for a cost of \$1.00 per page for the first 25 pages then \$.25 per page thereafter. Please allow 7-10 business days for records processing. Prepayment is required for this service.

**Prescription refills:** Prescription refills can take 48-72 hours to process due to the need to evaluate whether labs or office visits are necessary. Requests must be made before you run out of your medication, so we have ample time to approve your refill or notify you that an appointment is needed. Prescription refills will be handled during regular business hours only. Calling after regular office hours will not result in a medication being refilled.

**Controlled Substances:** Prescriptions for medications with the potential for misuse, abuse, or addiction are carefully monitored. Prescriptions for these medications will not be filled without an office visit first. Patients who lie or are otherwise dishonest about the use of these medications will be dismissed from the practice immediately & the proper authorities will be notified. We must abide by the federal regulations for these medications. Drug screening will be performed on a regular basis. You will be responsible for the charges for this service.

**Controlled substances should NOT be obtained from multiple physicians and/or multiple pharmacies. Lost prescriptions will not be refilled early. Stolen prescriptions require a police report.**

**Referrals:** Not all insurance companies require a referral to a specialist. If you do require a referral, please notify the office 48 to 72 hours in advance of the appointment. Failure to do so may result in rescheduling or non-payment by your insurance carrier. We will try our best to complete these in a timely manner, but please remember we are at the mercy of the insurance companies.

**Test results:** Patients will be asked to schedule an appointment to review test results (labs, x-rays, MRI's etc.) within two (2) weeks of completion. Please schedule an appointment once your test has been completed.

**Privacy:** We will maintain the privacy of your medical & personal information in accordance with the HIPAA laws established by the federal government. A copy of the HIPAA regulations will be provided to you, upon request. Unless authorized by the patient, family members should not inquire about patient medical information.

\_\_\_\_\_  
Patient and/or Guardian name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient and/or Guardian signature

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date



# Allergy Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever suffered from allergies? YES / NO

Have you ever had an allergy skin test? YES / NO If yes, when and where? \_\_\_\_\_

Do you have any food allergies or intolerances? YES / NO If so, what foods? \_\_\_\_\_

Are your allergy symptoms (check all that apply)?

\_\_\_ Currently Present \_\_\_ Worsening \_\_\_ Seasonal \_\_\_ All year long

During what months of the year do you experience symptoms?

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Which of the following triggers and/or makes your symptoms worse?

- Mowing grass
- Dusting
- Low/Damp places
- Other: \_\_\_\_\_
- Animals
- Outdoors
- Warm air
- Cool air
- Change in Temp.
- Foods

Are you currently taking any over the counter or prescription medications for allergies?

YES / NO If so, what medications? \_\_\_\_\_

When was the last dosage? \_\_\_\_\_

Are you on a beta blocker? YES / NO

If so, what medication and date/time of last dosage? \_\_\_\_\_

Do you have a history of any of the following?

- Hypertension
- Asthma
- Diabetes
- Heartburn/ Reflux
- Snoring
- Autoimmune Disorder
- Emphysema/COPD
- IBS
- Constipation
- Other: \_\_\_\_\_
- Throat Clearing
- Eczema/ Rashes
- Migraines
- Congestion or Sinus Infections
- Dry/Itchy Eyes
- Food Allergies
- Fatigue
- Itchy or Clogged Ears
- Respiratory Infections
- Seizures
- Cancer
- Diabetes
- Shortness of Breath
- Chest tightness
- Excessive Sneezing
- Post Nasal Drip

Women Only: Are you pregnant or trying to become pregnant? YES / NO

Get on the road to living allergy free. Talk to your physician about in house allergy testing.  
Results are available the same day!

**THIS SECTION IS FOR TEENAGERS AND IS TO BE COMPLETED BY THE TEEN**

	<b>YES</b>	<b>NO</b>
Do you use tobacco?		
Do you drink beer or any other alcoholic beverages?		
Do you use any kind of drugs?		
Are you sexually active?		
If YES to above, do you use birth control/protection?		
Have you ever been pregnant or fathered a child?		
Do you have concerns about safety issues?		
Do you have concerns about substance use (drugs/alcohol/tobacco)?		
Do you have concerns about sexually transmitted diseases?		
Do you have concerns about family planning?		
Other concerns or questions? (explain below)		

Other: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_