DIVAKER PEDIATRICS
Patient Information (Please Print)

Patient's Last Name_____ First Name_____ Middle
Name_____ Suffix_____ Gender ____M ____F DOB ___/___/___ DATE: _____
Race_____ Ethnic Group____ Hispanic ____ Non-Hispanic ____Unknown
Preferred Language_____

Mailing Address_____ City_____ State____ Zip_____
Home Address_____ City_____ State____ Zip_____
(Disregard if same address)

Home Ph#:_____ Cell Ph#_____ Work Ph#_____
Email Address_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS PATIENT
Self_____ Spouse_____ Parent_____ Other_____
Last Name_____ First Name_____ Mid Initial____
SSN___-___-___ DOB___/___/___ Home Ph#:_____
Cell Ph#:_____ Work Ph#_____
Street Address_____ City_____ State____ Zip Code_____
Employment Status (check one) ____Full-Time ____Part Time ___Retired Retired Date_____

POLICY HOLDER INFORMATION (If different from Patient). If same as responsible, please check here_____

Self_____ Spouse_____ Parent_____ Other_____
Last Name_____ First Name_____ Mid Initial____
SSN___-___-___ DOB___/___/___ Home Ph#:_____
Cell Ph#:_____ Work Ph#_____
Street Address_____ City_____ State____ Zip Code_____
Employment Status (check one) ____Full-Time ____Part Time ___Retired Retired Date_____

Emergency Contact (Parent/Guardian if patient is a minor)
Name_____ Relationship_____
Home Ph#_____ Cell Ph#_____ Work Ph#_____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST.
PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment by the assigned healthcare provider as may deem necessary to the patient name above.

Patient, Parent, Legal Guardian or Authorized Representative _____ Date _____

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Divaker Pediatrics. I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account balance for any professional services rendered.

Patient/Representative Signature _____ Date _____

ADVANCED DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

___I have executed an Advance Directive (Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate)

___I HAVE NOT executed an Advance Directive

Patient Signature _____ Date _____

Divaker Pediatrics
Rezia Divaker, M.D.
DIPLOMATE, AMERICAN BOARD OF PEDIATRICS

PEDIATRIC HEALTH QUESTIONNAIRE

Child's Name:	**DOB:**	**Date:**
Mother's name:	**Father's name:**	**Daycare/school:**
Address:		
Home Phone:	**Cell phone:**	**Work Phone**

HISTORY TO BE FLLED OUT BY PARENT OR GUARDIAN (please put an x next to YES or NO)

PREGNANCY AND BIRTH

1. Did the mother have any illness or problems during pregnancy: __Yes __No
2. Did the baby come on time: ____Yes ____No
3. What was the birth weight: _____
4. Did the baby have any problems just after birth: ___Yes ___No
5. Did the baby have any trouble while he was in the hospital: ____Yes _____No
6. Where was the baby born:_____

FEEDING AND DIGESTION

1. Was there sever colic or any unusual feeding problems in the first 3 mos: ____Yes ____No
2. Is your child appetite usually good: ____Yes ____No
3. Is it good now: ____Yes ____No
4. Do any foods disagree with him/her: _____Yes _____No
5. Does he/ she often have diarrhea: _____Yes _____No
6. Is constipation a problem: _____Yes _____No
7. Does he/she take vitamins: _____Yes _____No
8. If still on formula, which one do you use:_____

FAMILY HISTORY (Please list relative and if they are maternal or paternal.)

1. Are the child's parents both in good health: _____Yes _____No
2. Does either parent smoke? _____Yes _____No
3. List ages, sex, and general health of brothers and sisters:

_____

4. Mark X next to any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers or sisters have had: ___ Tuberculosis___Diabetes ___Asthma___Allergy ____Seizures____Cancer___Mental____Illness____Inherited Diseases_____Hypertension _____ Heart Disease_____ Alcoholism
5. Have any of your children died: _____Yes _____No

MEDICAL HISTORY/DEVELOPMENT

1. Has your child had more than 4 bouts of ear infections in one year: _____Yes _____No
2. Does he/she have more than 3-4 colds or sore throats with fever in a year: ____Yes ____N
3. Does he/she have trouble with urination: ____Yes _____No
4. Has he/she ever had a convulsion: ____Yes ____No
5. Does he/she hear well: _____Yes ____No

PEDIATRIC HEALTH QUESTIONNAIRE (cont'd)

6. Has he/she has any trouble with eyes: _____Yes _____No
7. At what age did he/she sit alone: _____
8: At what age did he/she walk alone: _____
9. Did your child say any words by the time he/she was 18 mos old: _____Yes _____No
10. Does he/she have any trouble sleeping now: _____Yes _____No
11. Are there any concerns with his/her teeth: _____Yes _____No
12. Has your child had any serious accidents or broken bones: _____Yes _____No
13. Does he/she take daily medications: _____Yes _____No
14. Other diseases or serious illnesses: _____
15. Any hospitalizations: _____Yes _____No
    For what: _____
16. Any operations : _____Yes _____No
    For what: _____
17. Has he/she had chicken pox: _____Yes _____No

ALLERGIES

1. Has your child ever had eczema or hives: _____Yes _____No
2. Has your child ever had wheezing or asthma: _____Yes _____No
3. Has he/she had any allergies or reactions to any medicines or injections: _____Yes _____No
   List _____

PSYCO-SOCIAL HISTORY:

1. Is your child doing well in school: _____Yes _____No
2. Does he/ she get along well with other children: _____Yes _____No
3. Does your child have any behavior problems that concern you: _____Yes _____No
4. Daycare/ Babysitter: _____Yes _____No

IMMUNIZATIONS

1. How many "DPT" or Diphtheria, Tetanus, and Whooping cough shots has your child had: _____
2. How many doses of polio vaccine by mouth (OPV): _____
3. Has your child had the measles/mumps/rubella vaccine: _____Yes _____No
4. Has he/ she had a skin test for TB: _____Yes _____No
   Date of last _____
5. Any other vaccines:
   List: _____

Parent Signature: _____

Relationship: _____ **Date:** _____

Divaker Pediatrics
Rezia Divaker, M.D.
Diplomate, American Board of Pediatrics

Vaccine Administration Consent

The doctor will keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number and the signature and title of the person who gave the vaccine.

"I have been provided a copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Material(s) and have read, or have had explained to me, information about the diseases and the vaccines listed below. I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or the person named below (for whom I am authorized to make this request)."

Information about Person to Receive Vaccine (please print)

Name: _____

Signature of Person to Receive Vaccine or Authorized to Make the Request (Parent or Guardian)

Signature: _____ **Date:**_____

Print Name: _____**Relationship:**_____

VACCINE TO BE GIVEN:

- **Prevnar**_____
- **Tetanus and Diphtheria (Td)**_____
- **Tetanus**____
- **Diphtheria, Tetanus, Pertussis, Hib titer**_____
- **Measles, Mumps, Rubella (MMR)**_____
- **Measles**_____
- **Hepatitis B**_____
- **Hib titer**_____
- **Oral Polio Vaccine (OPV)**_____
- **Inactivated Polio Vaccine (IPV)**____
- **Varivax**_____
- **Other**_____

DIVAKER PEDIATRICS

Written Acknowledgement of Receipt of Divaker Pediatrics Notice of Patient Privacy Practices

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of Divaker Pediatrics Notice of Patient Privacy Practices.

Patient or Legal Representative Signature_____

Printed Patient or Legal Representative Name_____

Relationship to Patient_____

Date_____

Acknowledgement NOT obtained because:

____Patient, or legal representative, declined to accept Notice of Patient Privacy Practices:

____Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement

____Other_____

_____

Employee Signature_____

Printed Name of Employee_____

Date_____

DIVAKER PEDIATRICS

COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

Please complete the following information for all requests

1. Today's date: _____

2. Patient name: _____

3. Date of Birth: _____

4. Address: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

You may leave the following messages on voicemail:

- Referral information
- Prescription refill information
- Test results
- Other: _____

You may discuss information regarding my treatment and care with the following family members and /or friends (name and phone number please):

_____

_____

_____

You may contact me regarding my treatment and care at the following numbers:

_____

_____

_____

Signature of Patient or Guardian_____ Date_____

Signature of Staff Person_____ **Printed Name of Employee**_____

DIVAKER PEDIATRICS

NO SHOW FEE ACKNOWLEDGEMENT FORM

DIVAKER PEDIATRICS CHARGES A $20 FEE FOR PATIENTS THAT NO SHOW FOR SCHEDULED APPOINTMENTS. IF YOU ARE UNABLE TO KEEP THE APPOINTMENT PLEASE CALL US TO RESCHEDULE OR YOU WILL BE SUBJECT TO $20 NO SHOW FEE.

Patient's Name: _____

Patient or Guardian Signature
(If patient is a minor): _____

Date: _____

Employee Name: S. Cauley

Employee Signature: S. Cauley

DIVAKER PEDIATRICS

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICALRECORD)

Part A: Must be completed for ALL Authorizations

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information (medical record) for the limited purposes, and in the limited manner, described in this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name:_____
Home Address: _____
DOB:____/____/____

Previous physician providing the information: (Complete w/Address)

Persons/organizations receiving this information: (Complete w/Address)

Divaker Pediatrics
6551 N Orange Blossom Trail, Ste 229, Mount Dora, FL 32757
352-383-8384 (Phone) 678-553-0329 (Fax)
Dr. Rezia Divaker

The following items must be initialed to be included in the use or disclosure of other health information:

_____**HIV/AIDS related health information and/or records.**
_____**Mental health information and/or records**
_____**Genetic testing information and/or records**
_____**Drug/alcohol diagnosis, treatment and /or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.**

Part B: Must be completed only if Divaker Pediatrics has requested the Authorization

1. Divaker Pediatrics must complete the following:
   a. What is the purpose of the use or disclosure? (Check one.)
   __x__At the patient's (or the patient's representative's) request or direction.
   _____For marketing _____For fundraising
   _____Other

b. Will Divaker Pediatrics requesting the Authorization, receive financial compensation of any kind, directly or indirectly in exchange for using or disclosing the health information? _____Yes ____X__No

2. The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will NOT be affected if I DO NOT sign this form. * Initial:_____

b. I understand that I may see and copy the information described on this form if I ask for it and that I get a copy of this form after I sign it. * Initial:_____

Part C: Must be completed for ALL Authorizations

The patient or the patient's representative must read and initial the following statements:

I understand that this authorization will expire (Please choose 1 of the 3 options below):

a. No expiration (permitted only for Authorizations used to create or maintain research databases or repositories.) Initial_____

b. On ____/____/____ Initial_____

c. When the following event occurs:_____
Initial:_____

*Signature:_____ Date:____/____/____
Of Patient or Patient's Representative
(Form MUST be completed before signing)

*Print Name of Patients Representative:_____
*Relationship to Patient:_____

*Reason Authorization is signed by the Patient's representative (check one)
_____Minor
_____Incompetent
_____Other (Explain)_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

*If this Authorization form authorizes use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/ or disclosure of any other protected health information. A separate Authorization form is needed for any other use and/or disclosure.