DIVAKER PEDIATRICS
Patient Information (Please Print)

Patient's Last Name______________________ DATE: ______
Name________________ Suffix______ Gender ____M ____F DOB ___/___/___ First Name______________ Middle
Race______________ Ethnic Group____ Hispanic____ Non-Hispanic_____ Unknown
Preferred Language______________________

Mailing Address______________________
Home Address______________________ City__________ State____ Zip________
(Disregard if same address)______________ City__________ State____ Zip________

Home Ph#:________________ Cell Ph#________________
Email Address______________________ Work Ph#____________

WHO IS FINANCIALLY RESPONSIBLE FOR THIS PATIENT
Self______________ Spouse____________ Parent__________ Other__________
Last Name________________ First Name______________________
SSN______-______-________ DOB____/____/____ Home Ph#:______________ Mid Initial____
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______________________
SSN______-______-________ DOB____/____/____ Home Ph#:______________ Mid Initial____
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

NEW BORN QUESTIONNAIRE

Child's Name: ______________________________ **Date:** ______________
Mother's Name: ______________________________ **Father's Name:** ______________
Address: ____
Home Ph: ______________ **Work Ph:** ______________ **Cell Phone:** ______________

HISTORY TO BE FILLED OUT BY PARENT/GUARDIAN

Pregnancy and Birth

1. Mother's age during pregnancy:________
2. Did you go for prenatal care:__________ How many visits:__________
3. Did mother have any illness during pregnancy:__________________
4. Did you have Group B Strep (GBS) infection:______
5. Did you have any STD (Herpes, HIV, Syphilis, Gonorrhea, Chlamydia, Hepatitis) during pregnancy: ____Yes ____No
6. Did any other baby in your family get sick with GBS: _____Yes _____No
7. Did you take any medications during pregnancy: ___Yes ____No
8. How many weeks was baby at time of birth:_______
9. How much did the baby weigh:_______
10. Which hospital was baby born at: ______________
11. After how many days was discharge: _______
12. Was baby sick when born: _____Yes _____No
13. Did baby receive any medication: _________
14. Any surgeries: ____

FEEDING AND DIGESTION

1. Was there any severe colic or any unusual feeding problems: ____Yes ______No
2. Did you breast feed: ______Yes ____No
3. Does child have good appetite: ______Yes _____No
4. Any diarrhea: ______Yes _______No
5. Constipation: ____Yes ____No
6. If taking any formula, which one: _______________
7. Any allergies: ______Yes ______No

SOCIAL HISTORY

1. Who lives with the child (please include name, relation, age and gender)
____

2. Mark an X next to any of the following diseases that child's parents, grandparents, brothers, sisters, aunts or uncles have had: __ Tuberculosis___Diabetes ___Asthma___Allergy ____Seizures____Cancer___Mental____Illness____Inherited Diseases_____Hypertension _____ Heart Disease_____ Alcoholism

Divaker Pediatrics
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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.