ORLANDO HEALTH
1414 Kuhl Ave. • Orlando, FL 32806

LINE UP PATIENT I.D. LABEL HERE

PEDIATRIC ENDOCRINOLOGY SUBSPECIALTY PRACTICE

Welcome to Pediatric Endocrinology Faculty Practice. We appreciate you selecting our office for your care. To better serve you, below are answers to our most frequently asked questions.

Will I be able to schedule my appointments at the specific time I need to fit my busy schedule?
We make every attempt to work with your schedule and find times that are most beneficial to you. There are "prime" times that book up quickly and are available on a first-come basis.

Will you handle all insurance verifications and authorizations?
We are happy to file claims with your insurance carrier as a courtesy to you. It is your responsibility to confirm coverage and any unpaid balance will remain your responsibility.

When will I need to pay my portion of my services?
On each visit, we will collect your co-pay, insurance deductible and/or percentage. However, the balance of your bill will remain your responsibility until paid by your insurance carrier. We encourage you to follow through on any requests from your carrier to improve the probability of payment by your insurance.

What is your cancellation/ no-show policy?
We request cancellations be made at least 24 hours in advance. Following three missed appointments (no-shows) the patient will be discharged from the practice. You will be charged a no-show fee of $25.00 for a missed appointment.

When should I arrive for my appointment?
Arrive 10 minutes before your scheduled appointment. This gives the staff ample time to prepare for your scheduled treatment. If you find that you are unavoidably late for an appointment, call to make certain that the physician will still be able to see you or to re-schedule. Patients arriving at their correct appointment time will be given priority. If you arrive 20 minutes after your appointment time you will need to reschedule.

What is your policy on prescription refills?
We request a 3-4 business day notice for all medication refills. We do not call in prescriptions after hours or on weekends.

What is the policy for Diabetes School forms?
School forms must be filled out completely by the parent/legal guardian and will be reviewed and signed at the time of visit by the physician. Please bring forms with you to your summer appointment.

We hope that this information will be useful in answering questions that you may have; however, the entire staff is always available to discuss with you any medical or financial questions.

_____
Patient Name

_____
Parent/Guardian Signature Date Time

_____
Witness Date Time

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone: _____ Language: _____

PHYSICIAN GROUP
ORLANDO HEALTH

PATIENT INFORMATION

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Today's Date _____/ _____/ _____ ❑ Returning Patient ❑ New Patient

Were you referred by a doctor's office?	❑ No ❑ Yes (Complete physician information)
Referring Physician	Phone
Referring Physician Address	

PATIENT INFORMATION

Patient Name (Please Print)		Age
Social Security Number	Sex ❑ Male ❑ Female	Birthdate
Street Address		
City and State	Zip Code	Home Phone

GUARDIAN INFORMATION

Primary Guardian	Birthdate	Relationship to patient
Home Phone		Other Phone Number
Street Address, City, State (if different)		
Parent/ Guardian Employer		Occupation
Word Address, City, State		Work Phone
Secondary Guardian Name	Birthdate	Relationship to Patient

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to patient _____

Address _____ Phone Number _____

All charges are due at time of service, including copays and patient responsibility charges.

PLEASE COMPLETE BOTH SIDES OF FORM

PHYSICIAN GROUP
ORLANDO HEALTH

PATIENT INFORMATION

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INSURANCE AND PAYMENT INFORMATION

Person Responsible for Payment _____ Relationship to patient _____

Social Security Number _____ Home Phone Number _____

Other Phone Number _____

Street Address , City, State(indicate If Permanent) _____

_____

❑ Primary insurance
Group Number _____
Policy Number _____
Name of Policyholder _____
Date of Birth _____

❑ Secondary insurance
Group Number _____
Policy Number _____
Name of Policyholder _____
Date of Birth _____

Complete section below if appointment is related to accident

Type of injury _____ Date of injury _____

Was An Automobile Involved? ❑ Yes ❑ No Name of Automobile Insurance Company _____

PAYMENT RESPONSIBILITY STATEMENT

I understand that a claim for today's services will be submitted to my Insurance Company, if applicable. I am responsible for copayments, payment of any remaining unpaid balance, and/or payment in full if my insurance company does not make payment.

Signature of Person Responsible for Charges _____ Date _____ Time _____

Witness _____ Date _____ Time _____

PERMISSION FOR ALTERNATE CAREGIVER

PLEASE NOTE: Due to patient confidentiality and safety, the Orlando Health Medical Education Outpatient Centers will only be able to see the patient:

1. If the guardian is with the patient; or
2. If the person bringing the patient in to be seen is listed in the Alternate Caregiver section below.

The people listed below have my permission to bring _____ (patient's name) to the Orlando Health Medical Education Faculty Practices for treatment.

Signature of Guardian _____ Date _____ Time _____

Witness Signature _____ Date _____ Time _____

1. Name _____ Relationship to Patient _____
   Address _____ Phone Number _____
2. Name _____ Relationship to Patient _____
   Address _____ Phone Number _____
3. Name _____ Relationship to Patient _____
   Address _____ Phone Number _____

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone: _____ Language: _____

ARNOLD PALMER HOSPITAL
For Children
Supported by Arnold Palmer Medical Center Foundation

PEDIATRIC SPECIALTY PRACTICE

LINE UP PATIENT I.D. LABEL HERE

HEALTH RECORD

❑ Craniofacial ❑ Pulmonology ❑ Gastroenterology ❑ Nephrology ❑ Endocrine ❑ Orthopedic ❑ Rheumatology
❑ Spina Bifida ❑ Infectious Disease ❑ Neurosurgery ❑ Neuropsychology ❑ _____

Date: _____ Completed by: ❑ Patient ❑ Parent/Guardian ❑ Other _____

PLEASE COMPLETE THE FOLLOWING SECTIONS AS FULLY AS POSSIBLE

ALLERGIES

Are you ALLERGIC to any medications, food, or other? ❑ No ❑ Yes/List all ALLERGIES and describe your reaction:

_____

_____

CURRENT MEDICAL HISTORY

What health problem has brought you here today (reason for visit)? ❑ Check-up ❑ Problem (please list)

_____

When did this problem start? _____

How long does it last? _____ (exp: 1 hour, 1 day) Where is the problem area? _____

Is the problem getting: ❑ same ❑ better ❑ worse

Have you received any treatment for this problem? ❑ No ❑ Yes/List type of treatment and where and when received:

_____

Date/Age of first menstrual period: _____

PAIN: Do you have any ongoing pain problems? ❑ No ❑ Yes Do you have pain now? ❑ No ❑ Yes

PAST MEDICAL AND SURGICAL HISTORY

Please check **ALL** previous illnesses or conditions below.

❑ Heart problems ❑ Heart murmur ❑ Lung problems ❑ Asthma ❑ Mental illness
❑ High blood pressure ❑ Liver problems ❑ Stomach problems ❑ Stroke ❑ Seizures
❑ Circulation problems ❑ Neurological problems ❑ Bone pain/problems ❑ Cancer
❑ Kidney/urine problems ❑ Bleeding problems ❑ Thyroid problems ❑ HIV/AIDS
❑ Diabetes or sugar in urine ❑ Sexually transmitted disease ❑ Muscle weakness/Musculoskeletal problems
❑ Recent weight loss/gain. ❑ No ❑ Yes If yes, how much? Loss _____ Gain _____
❑ Other: _____

Please provide more information below for any of the conditions or illnesses you checked above.

_____

_____

List **ALL** past surgeries and procedures (Include type of surgery and date):

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please check **ALL** illnesses or conditions below that run in your family (blood relatives).

❑ Heart problems ❑ Heart murmur ❑ Lung problems ❑ Asthma ❑ High blood pressure
❑ Liver problems ❑ Stroke ❑ Circulation problems ❑ Bleeding problems ❑ Stomach problems
❑ Mental illness ❑ Seizures ❑ HIV/AIDS ❑ Cancer ❑ Thyroid problems
❑ Kidney/urine problems ❑ Bone pain/problems ❑ Neurological problems
❑ Diabetes or sugar in urine ❑ Muscle weakness/Musculoskeletal problems ❑ Other: _____

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FALLS ASSESSMENT *(Check all boxes that apply)*

Do you have any problems with your vision? ❑ Have you ever fallen due to a medical problem? If yes, when?_____
Do you have any of the following devices?
❑ Dental appliance ❑ Pulse oximeter ❑ central line ❑ vagal nerve stimulator ❑ BiPAP
❑ CPAP ❑ ventilator ❑ cochlear implant ❑ myringotomy tubes
❑ continuous glucose monitoring ❑ SQ Insulin Infusion Pump ❑ Implantable pump ❑ Baclofen pump
Do you have any history of falls/near falls? ❑ Yes ❑ No
Explanation of falls/near falls history
❑ Leg Braces ❑ A/B Monitor ❑ Wheelchair ❑ Other assistive devices _____

DEVELOPMENT AND SOCIAL HISTORY

Birth: ❑ Full-term ❑ Premature Weeks of pregnancy _____ Birth Weight ____lb _____oz.
❑ Vaginal ❑ C-Section ❑ head first ❑ Feet or bottom first (Breech) length of infant hospital stay
Age at first Time: _____ Sitting _____ Crawling _____Walking _____Words _____Toilet training
❑ Right-handed ❑ Left-handed Problems with using hands or fingers: _____ ❑ None
Sports Participation: _____ Favorite Activities: _____
School: _____ Grade:_____ Usual report card grades: _____

Name of medication/vitamin/herbal preparations	DOSE	Initials	How often	Reason for taking	Length of time taken

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FOR CLINICAL STAFF: INITIAL IF PHYSICIAN REVIEW REQUIRED

IMMUNIZATIONS/VACCINES

Are the childhood immunizations up to date? ❑ Yes ❑ No
Are siblings immunizations up to date? ❑ Yes ❑ No

MDRO/Infectious Process Screen

History of MDRO (multi-drug resistant organisms), MRSA/VRE? _____
❑ No ❑ Yes - Initiate Contact Precautions ❑ unable to obtain/refused

Infectious Process Screen: _____
❑ No signs of infectious process ❑ Temp. 100.4 (38C) ❑ wounds with purulent drainage or erythema
❑ new onset cough with fever or new onset SOB with fever ❑ signs of sepsis (Temp > 100.4 F (38 C) and hypotension ❑ Rash with Temp > 100.4 F (38 C) _____

TUBERCULOSIS (TB) SCREENING

1. Pediatric (children younger than 12)
Does the child, any member of the household, or anyone who frequently visits the household have TB? _____
❑ No ❑ Yes – **(Inform the Front Desk immediately)**
Does the child age 12 or greater (excluding Cystic Fibrosis patients), any member of the household, or anyone who frequently visits the household have a cough that has lasted longer than 2 weeks? _____
❑ No ❑ Yes – (Complete the Adult TB Assessment on the child or adult in question)
Adult's Name _____ Relationship to Patient _____

2. Adult (check the box if the answer is YES. If the answer is NO, leave blank)

❑ Cough for longer than 2 weeks [3]
❑ Blood in the sputum [5]
❑ Fevers or night sweats [2]
❑ Recent unexplained weight loss of > 10 lbs [2]
❑ Recent exposure to TB [2]
❑ History of TB or active TB (even if on meds) [5]
❑ Jail in the past two years [2]
❑ HIV positive [2]
❑ Homeless or living in a shelter [1]
❑ Foreign born (Asia, E. Europe, Latin America, Africa) [1] _____

USE OF TOBACCO PRODUCTS

Do you smoke or use tobacco of any kind? ❑ No ❑ Yes*
If patient is a minor and does not smoke, does anyone living in the house with the patient smoke? ❑ No ❑ Yes*
*Would you like to receive information on how to stop using tobacco products? ❑ No ❑ Yes

USE OF DRUGS AND ALCOHOL PRODUCTS

Do you have a history of substance abuse? ❑ No ❑ Yes (complete questions below)
Type _____ Amount _____ Type _____ Amount _____
Type _____ Amount _____ Type _____ Amount _____

PSYCHOSOCIAL SCREENING

Do you feel safe at home? ❑ No ❑ Yes

ADVANCE DIRECTIVES – (COMPLETE ONLY IF OLDER THAN 18)

Do you have a Healthcare Surrogate? ❑ No ❑ Yes Do you have a Living Will? ❑ No ❑ Yes

SIGNATURE OF PERSON COMPLETING FORM: _____

For Office Use

Nursing/MOA Review: _____ Title _____ Date _____ Time _____
Physician/Practitioner: _____ I.D.# _____ Date _____ Time _____

STOP: OFFICE STAFF WILL COMPLETE BACK PAGE

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TO BE COMPLETED BY OFFICE STAFF

Nursing/MOA Staff: Place your initials next to any "Yes" answers that require physician review

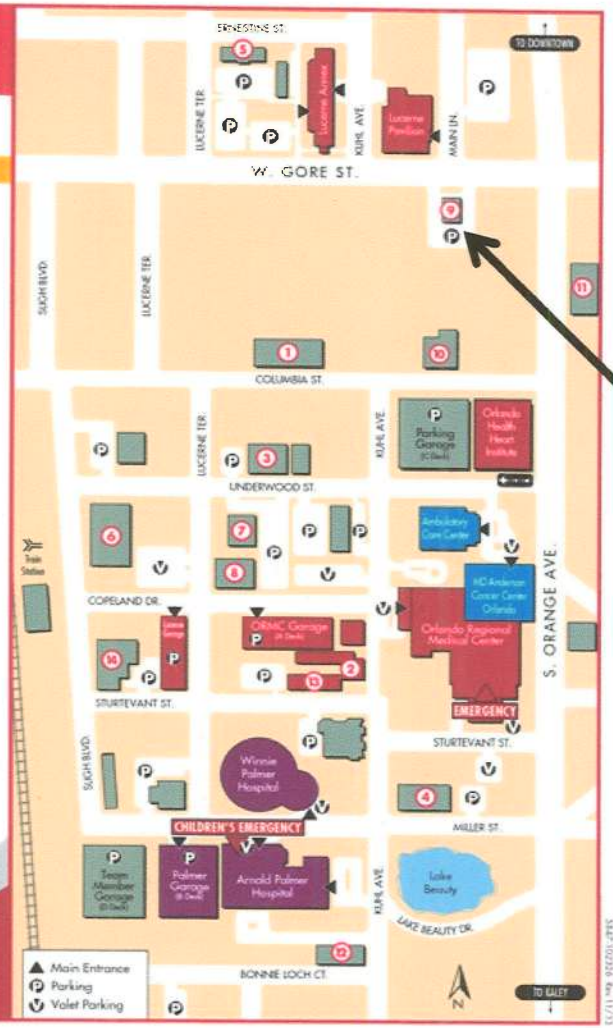
	INSTRUCTIONS
IMMUNIZATIONS	If current per parent/guardian, verify on Vaccine Administration Record (VAR) (General Pediatrics Only)
CONTAGIOUS DISEASES	If "Yes" to any of these notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk.
IF A HISTORY OF MRSA/VRE	Initiate MRSA/VRE Protocol orders #5872-96739
TUBERCULOSIS (TB) SCREENING	**Pediatric [younger than 12] – if "Yes" to this**, notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk. **Adults [12 and older] – add up points:** Total points _____ If the patient has received 5 or more points, place a TB mask on the patient and place in a private room, using Airborne precautions. Contact the physician for an assessment.
USE OF TOBACCO	If a patient answers yes to: *Would you like to receive information on **PRODUCTS** how to stop using tobacco products?" offer the **TIPS TO KICK TOBACCO** booklet through Smartworks (4767-46341).
PSYCHOSOCIAL SCREENING	*Any "No" answer must be addressed. Refer to Corporate P&P that details the requirements for healthcare workers.* **SUSPECTED CHILD, ELDERLY, OR MENTALLY HANDICAPPED** **ABUSE OR NEGLECT: IDENTIFICATION AND REPORTING #1600** **SUSPECTED DOMESTIC VIOLENCE REPORTING (ADULT) #1625** **Abuse Hotline: 1-800-96-ABUSE**
FALLS ASSESSMENT	If any special assist devices are checked, patient is increased risk for falls. Make sure the environment is safe and free of obstructions.

ORLANDO HEALTH

Downtown Orlando Campus

- **Emergency Department & Level One Trauma Center** 1414 Kuhl Ave.
- **Children's Emergency Department & Trauma Center** 92 W. Miller St.
- **Orlando Regional Medical Center** 1414 Kuhl Ave.
- **Arnold Palmer Hospital for Children** 92 W. Miller St.
- **Winnie Palmer Hospital for Women & Babies** 83 W. Miller St.
- **MD Anderson Cancer Center Orlando** 1400 S. Orange Ave.
- **Orlando Health Heart Institute** 1222 S. Orange Ave.
- **Lucerne Pavilion** 818 Main Ln.
- **Ambulatory Care Center** 22 W. Underwood St.

1. Arnold Palmer Hospital Specialty Practices 83 W. Columbia St.
2. Clifford E. Graese Library 1414 Kuhl Ave.
3. Occupational Health 77 W. Underwood St.
4. Hubbard House 29 W. Miller St.
5. Human Resources 85 W. Gore St.
6. Winnie Palmer Hospital Surgical Pre Testing 1301 Sligh Blvd.
7. Medical Education Administration 86 W. Underwood St.
8. Medical Education Outpatient Clinic 89 W. Copeland Dr. Access from Underwood St.
9. Orlando Health Medical Pavilion 32 W. Gore St.
10. Obstetrics/Gynecology 21 W. Columbia St.
11. Rehabilitation, Children 925 S. Orange Ave.
12. Ronald McDonald House 1630 Kuhl Ave.
13. Thorsen Building 65 W. Sturtevant St.
14. Wellness Center 119 W. Sturtevant St.



http://www.arnoldpalmerhospital.com/pediatric-specialties/pediatric-endocrinology-and-diabetes

Pediatric Endocrinology Providers:
Dr. Richard Banks
Dr. Paul Desrosiers
Dr. Jennifer Villar
Dr. Joshua Yang

60 West Gore St 2nd Floor
Orlando, FL 32806

Parking in the back of the building