WELCOME TO SUNSHINE PEDIATRICS!

Congratulations to you and your family!

Sunshine Pediatrics is thrilled to welcome you and your new addition to our practice. Children are a blessing and we are honored to care for them with you on their journey through life from cradle to college.

At this informal gathering – our services, office policies and philosophies of care for children are explained. We also like to show you around the office and see that all your important questions are answered regarding what to expect when visiting our office and how we go about helping you as a new parent get off on the right food in the wonderful world of parenting.

The big day!

If you are planning on delivering your baby at a birth center or home birth with one of our affiliated mid-wives, simply tell them you have chosen Sunshine Pediatrics as your pediatrician. This allows for proper documentation to be forwarded to Sunshine Pediatrics concerning the birth of your baby. Please call the office within 24 hours of your baby's birth to schedule an appointment with one of our providers. Prepare to be seen within 48 hours of delivery.

If you are planning a hospital birth or ultimately end up delivering at a hospital, simply tell the hospital staff you have chosen Sunshine Pediatrics with Dr. Richard Rodriguez as your newborns pediatrician. This allows the proper documentation to be forwarded to Sunshine Pediatrics concerning the birth of your baby. Once discharged from the hospital, please contact our office to be scheduled for an appointment with one of our providers. Prepare to be seen within 3-5 days of delivery (unless specified per the hospital).

Office Hours:

Monday, Wednesday, Friday	Tuesday & Thursday
8am to 5pm	8am to 7pm
	5pm to 6pm is **reserved** for walk-ins
	6pm to 7pm is **reserved** for established patient well-visits

Well-child appointments and sick-child appointments are available every day. Please schedule any well-child visit 24 hours prior to requested time. Sick visits can be made for same-day appointments.

Appointments:

- Please arrive 15 minutes before each appointment to complete the check-in process
- There is a 15 minute grace window if you are running late. After that, your appointment will be rescheduled at a $35 fee. Please allow for a 24 hour notice in any changes to the appointment.
- 12 visits during the first 2 years; we ask that you come to all of them, even if your child is well.

After hours EMERGENCY

- Call the office, follow the prompts, and leave a detailed message. Your call will be returned within 30 minutes. REPEAT PHONE NUMBER please.
- Any non-emergent issues can be subject to fee. After hour phone calls are NOT for insurance questions, appointment making/cancelling, prescription refills, etc.

Newborns:

- MEDICAID is open to newborns. We accept Humana and Sunshine Health.
- We recommend mother's to seek out lactation services. Please ask your provider for more information.

Insurance:

- We accept both Medicaid and commercial insurance.
- Call your insurance the day the baby is born to add baby to a policy.
    - Sunshine Pediatrics is outpatient setting so a 30 day rule does not apply to this office.
- $175 will be collected at time of visit until baby has active insurance (in-network) in our system. The refund will be issued once we receive payment from insurance.
- If child is put on an HMO we are not in-network with, **no refund will be issued.**
- Follow up with your employers human resources.

Vaccine Friendly:

- Sunshine Pediatrics recommends that you vaccinate you child, but if you decide not to, we respectfully honor your decision.
- Know your own vaccine schedule and understand each vaccine.
- Please see attached schedule, RTV form, and vaccination policy.

Forms:

- $5 (each) for forms given outside of your well-visit; keep a master copy for your records.
- If someone other than the legal guardian is bringing a child, we need a notarized form.
    - Available on our website or in office.
- If transferring in to our practice, we ask for medical records to be faxed or given to us BEFORE any appointment is scheduled.
    - Medical release/request form available on our website or in office.

Patient Registration

(Please print)

Patient:

Last Name_________________________________ Patient First Name____________________________ Middle Initial _____

Sex: M___ F___ Date of Birth______________ Social Security #__________________

Mailing Address____

City__________________________ State_________ Zip Code__________ Home phone____________________________

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Preferred Language___________________________________ Referred By____

Siblings: Name Sex DOB SS#

____

____

____

Previous Physician___________________________ **Pharmacy Name and Number** __________________________________

Mother:

Last Name_________________________________ First Name__________________________ Date of Birth______________

Mailing Address (list if different) ____

City__________________________ State_________ Zip Code__________ Cell phone________________________________

Social Security #___________________________________ Marital Status ____

Email Address____

Father:

Last Name_________________________________ First Name__________________________ Date of Birth______________

Mailing Address (list if different) ____

City__________________________ State_________ Zip Code__________ Cell phone________________________________

Social Security #___________________________________ Marital Status ____

Email Address____

Who is financially responsible for the patient (Guarantor)? ____

Emergency Contact

Name______________________________________ Relationship_____________________ Number ____________________

Insurance Information

Primary Insurance

Name of Insurance Company_____________________________________ Phone Number____________________________

Mailing Address____ City_______________ State____ Zip Code_______

Insured's ID/Policy #_________________________ Group____________________

Main Policy Holder __________________________________ Policy Type: ☐HMO ☐ PPO ☐ PPC ☐Other_________

(CONTINUE TO BACK OF THIS PAGE)

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Print Patient Name____ Date_______________________

I hereby authorize the release or use of my/or the patient's individually identifiable health information ("protected health information") and medical record information by Sunshine Pediatrics of Central Florida (the "practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining the patient or discussing the patient's care, treatment or medical condition with you, by signing this consent form you are consenting to the disclosure of your protected health information to that third party.

The Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request, in writing, that we further restrict how the patient's protected health information is released or used to carry out our treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction (s); however, if we do agree, in writing, to your/the patient's requested restriction(s), such restrictions are then binding on the Practice.

I have been provided the opportunity to review the Practice's Notice of Privacy Practices in the waiting room and I understand I may receive a copy if I request it.

_____________________________________ __________________________________ ______________

Signature (parent/guarantor) **Print Name (parent/guarantor)** **Date**

I acknowledge and agree that the Practice may disclose my/the patient's protected health information and medical record information to the following individuals (other than parent): **(please initial line and write in name of individual)**

___ Spouse(other than child's parent)___________________________ ___ Grandparent__________________________________

___ Legal Guardian____ ___Other____

I agree that the Practice may also disclose the following types of information contained in the patient's medical record.

	General Medical Information		Drug/Alcohol Abuse
	Financial Information		Labs/Diagnostic Testing
	Psychiatric Information		Pregnancy Information if patient is under 18 years old

I agree and consent to the Practice releasing information to me in the following alternative manners **(please initial the appropriate spaces below):**

____Via regular mail ____Via telephone ____Via home answering machine ____Via email

The Practice may refuse to treat you if you the patient's authorized representative, do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

I have read and understand the information in this Consent. I am aware I can request a copy of this consent and I am the patients authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

_____________________________________ __________________________________ ______________

Signature (parent/guarantor) **Print Name (parent/guarantor)** **Date**

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to any evaluation or treatment that the assigned healthcare provider may deem necessary.

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Sunshine Pediatrics of Central Florida. 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.
We bill only primary insurance we are contracted with and the patient is expected to know what coverage they have. I understand that if my account is not paid in full by my insurance within 60 days of the date of service, I am responsible for payment in full.
Currently, we do not bill secondary insurances. In the event you have two insurances, we can provide you with any documentation necessary for you to submit a claim to your secondary insurance.

FINANCIAL POLICIES

Payment for all medical care is due at time of service.

In the case of divorced parents, responsibility and payment shall be that of the guarantor bringing the child in for treatment. Payment for co-payments, deductibles, co-insurance or any other balance not paid by your insurance company is owed prior to treatment.

There is a $35 returned check fee for any checks returned unpaid through Sunshine Pediatrics' bank.
I understand that, in the case of default, I am responsible for any costs incurred in the collection of patient account, currently 35% of the balance, as well as reasonable attorney fees and court costs.

During the course of your treatment, separate charges for laboratory, hospital or other services not offered directly by this office may occur. Our office is not responsible for billing these services. You may receive separate bills from these facilities. If you have questions regarding their charges, please contact these facilities directly.

I understand and agree to comply with Sunshine Pediatrics of Central Florida financial policy.

_______________________________________ ____________________________________ _______________

Signature (parent/guarantor) **Print Name (parent/guarantor)** **Date**

(CONTINUE TO THE BACK OF THIS PAGE)

OFFICE POLICIES

We provide an after-hours telephone service to our patients for cases of medical emergencies. **If you are needing to schedule or cancel an appointment, speak to our billing department or a nurse please do so during regular business hours of 8:30 am to 5 pm.** Abuse of the after-hours service for anything other than an emergency may result in a **non-negotiable fee**.

For prescription refills have your pharmacy fax a refill request to our office and allow 3 days for processing. Please do not call the after-hours telephone or office nurse for refills.

As a courtesy to both our providers and other patients, we ask that you contact our office immediately if you are going to be late to your scheduled appointment. If you arrive more than 15 minutes late to your scheduled appointment time, your appointment will be forfeited and rescheduled.

PATIENT INFORMATION

A standard charge for transferring medical records is required by law. Please be advised requesting the transfer of medical records can take up to 5 days to process. For a doctor to doctor transfer of records, there is no fee associated for the first time of transfer. After that, the transfer of medical records will cost $1 per page.

For school & daycare shot/medical forms, a flat fee of $5 is required for all school, daycare, shot and/or medical forms at the time of pick-up. These forms are often referred to as blue and/or yellow forms. As a courtesy, these forms will be filled out at no charge during the time of a well exam.

For patient referrals, please allow 5 days as a doctor referral can take up to 3 days to process the correct insurance authorization. If a referral is pending authorization it may be necessary to reschedule an appointment.

NO SHOW/SAME DAY CANCELLATION/WALK-INS POLICY

Our office reserves the right to charge the following fees to reschedule your appointments or procedure.
If you are not on time for your appointment, the appointment will be rescheduled and a fee will apply.
Excessive NO SHOW, LATE ARRIVALS or SAME DAY CANCELLATIONS of appointments can result in your DISCHARGE from the practice.

Appointment Type	Amount	Notice Needed
Office Visit (sick)	$35	24 hours
Office Visit (well or behavioral)	$50	48 hours

This charge is not covered by insurance and therefore will be the responsibility of the patient/parent.

______________________________________ ___________________________________ ______________

Signature (parent/guarantor) Print Name (parent/guarantor) Date

NEWBORN FEES

All visits, until we can verify the newborn's insurance coverage is active, will be on a self-pay basis. Once we have verification of active coverage, we submit the claims to your insurance company. After receipt of insurance payments, parents will be reimbursed a refund back to original form of payment minus any co-pays, deductibles, and co-insurance amounts.

ALL HOSPITAL, BIRTH CENTER, OR HOME BIRTH BABIES:

1ST VISIT WITHIN 24 HOURS	$175.00
3-5 DAY WELL VISIT	$175.00
2 WEEK WELL VISIT	$140.00

CIRCUMCISION PROCEDURE

ESTABLISHED PATIENT OF SUNSHINE PEDIATRICS WITH PRIVATE INSURANCE: $320.00

(We will bill your insurance company for this procedure 30 after 30 days. If your insurance company reimburses us, we will either cut you a check or put the payment for the procedure as a credit on your account. We do not bill Medicaid for this procedure.)

FRENOTOMY (TONGUE-TIE) PROCEDURE

ESTABLISHED PATIENT OF SUNSHINE PEDIATRICS:

(This procedure must be done separately and cannot be combined with well visit)

This procedure can be billed to Private or Medicaid insurance $210.00

NEWBORN INSURANCE POLICIES

Payment will be collected at the **time of service** for all newborn visits until we are able to verify the patient's eligibility on your insurance plan.

- We accept all commercial plans, please select Dr. Richard G Rodriguez as your PCP.
- For marketplace and Medicaid: Please verify with you insurance that Dr. Richard G Rodriguez is in network with your insurance, as we are not responsible for knowing every insurance plan available and out contact status with them. Also – please verify that Dr. Richard G Rodriguez is your selected PCP prior to ALL appointments.
- The Medicaid HMO's we are in network with are Humana and Sunshine Health. Once coverage is verified, the billing department will then bill all claims to insurance and you will be reimbursed for payments made.

NOTE: Refunds made will have deducted amount related to co-pay, co-insurance, and deductible amounts. If insurance is not in network or we are unable to bill, no refund will be issued.

Sunshine Pediatrics only **bills one insurance policy.** If you add your baby to two policies, we will only bill the primary insurance (which falls under the birthday rule: whoever's birthday is first in the year is considered the guarantor of the primary insurance).

Circumcisions are an **elective procedure.** Therefore, we require payment for this procedure at the time of service. It will then be submitted to your insurance once baby is active. If we receive payment from the insurance company, you will promptly be reimbursed.

I hereby **grant permission** to Sunshine Pediatrics of Central Florida to release any pertinent information to my insurance company upon request, and I authorize payment directly to Sunshine Pediatrics of Central Florida. A photo static copy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian/Guarantor Signature: ___________________________________

Parent/Guardian/Guarantor Print: ___________________________________

Date: _____________________

SUNSHINE PEDIATRICS OF CENTRAL FLORIDA

RICHARD RODRIGUEZ, M.D.

210 LOOKOUT PL, MAITLAND, FL 32751

PHONE 407-215-0400 FAX 407-215-0402

MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Sunshine Pediatrics. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible – no later than 24 hours prior to your scheduled appointment. This gives us time to schedule for other patients who may be waiting for an appointment.

Please see our appointment cancellation / no show policy below:

1. A **$35.00** no show fee will be applied to any sick visit missed appointment not cancelled with a 24 hour notice.
   Well visits/Med checks/Behavioral Visits need a 48 hour cancellation notice or **$50.00** no show/same day cancel fee will apply.

2. At the 2nd no show, you will receive a call from the office manager to give a reminder about a 3rd no show dismissal policy.

3. 3rd no show, the patient will receive a dismissal letter with a medical records form to find a new pediatric practice.

As a courtesy, when time allows, we make reminder messages for appointments. If you do not receive a reminder message, the above policy will still remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience these circumstances, please contact our office manager.

You may contact Sunshine Pediatrics Monday – Friday from 8am to 5pm at the number above. (Please leave a voicemail if you are calling over the weekend to cancel a Monday appointment for a no charge cancellation. If a voicemail is left on Monday morning, the policy remains).

I have read and understand the MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY and agree to its terms.

Parent/Guardian Signature: ______________________________ Date: __________________________

Relationship to Patient: ______________________________

SUNSHINE PEDIATRICS OF CENTRAL FLORIDA

RICHARD RODRIGUEZ, M.D.

210 LOOKOUT PL, MAITLAND, FL 3251

PHONE 407-215-0400 FAX 407-215-0400

INFORMED CONSENT PURSUANT TO FLORIDA STATUES SECTION 456.51 CONSENT REQUIREMENTS/EXPLANATION OF SCOPE OF CARE

The American Academy of Pediatrics (AAP) recommends that all children and adolescents have an annual well exam visit where screenings and a complete physical exam are performed. Once component of a complete physical exam is inspection and palpation of the external genitalia to ensure normal, age-appropriate development and to document that there are no abnormalities. We will verbally inform you/the patient prior to doing this part of the exam, as we know there is sensitivity, but we need to ensure each patient has been evaluated appropriately. Additionally, if a child or adolescent presents with complaints that could be attributed to the genital area or rectum, we may need to examine the genitals and/or complete a rectal exam to ensure an accurate diagnosis. Florida has passed a new law that requires any health care practitioner that is examining or treating a patient's pelvic region to obtain a written consent. **Though we do NOT perform examination of the ovaries, uterus, and fallopian tubes in our offices, given the broad definition of "pelvis examination" in the recently passed Florida legislation, in an abundance of caution, we are choosing to obtain the consent of each patient or their legally authorized representative for examination of external genitalia. This consent applies regardless of gender.** Our exam, procedures, and way of practice *has not* and *will not* change regardless of the new law. We will continue how we have always performed our physical exams but comply with the new requirement of consent.

CONSENT FOR EXAMINATION OF EXTERNAL GENITALIA

By signing below, the patient (or the patient's legal representative) acknowledges that he/she has been given the opportunity to ask questions about the external genitalia examination before signing the Informed Consent and that the patient (or the patient's legal representative) has voluntarily agreed to the external genitalia examination by a health care provider. If the patient lacks the capacity to sign this Informed Consent, this form will be signed by the person authorized to consent for the patient.

Under Florida Law, prior to performing a pelvic examination, consent must be obtained. While we do not perform internal pelvic exams in our office, the components below are included in the Florida Law and may be performed at this examination:

- External genitalia examination, including the penis, scrotum, vagina, and/or labia
- Examination of the perineal area or perianal area or rectum
- Taking of a rectal temperature in an infant
- Evaluation of labial adhesions or penile foreskin adhesions

The RISKS to the examination include (but are not limited to): discomfort.
The RISKS associated with failing or refusing to undergo the examination elements above include: the inability to obtain a diagnosis and/or delay in diagnosis of a medical condition, the inability for the health care provider to have accurate and complete information necessary to appropriately treat the patient, and potential for infection for situations in which the provider is unable to take a rectal temperature.

The **REASONABLE ALTERNATIVES** include a refusal for the intervention assessment. In such case, shared decision making between the patient and his/her provider is vital to ensure health and wellbeing.
The **BENEFITS** include ability to obtain a diagnosis of a medical condition and the ability for health care providers to have accurate and complete information necessary to appropriately treat the patient.

This consent is in legal good standing and has no expiration, until otherwise revoked and a refusal is signed and on file. If you have any questions, please talk with your Sunshine Pediatrics health care provider

I acknowledge that this consent was given freely voluntarily. By signing below, I confirm that I have read, fully understand and consent to Sunshine Pediatrics of Central Florida conducting a pelvic exam. I also acknowledge that I understand the information in this form, including the purpose, risks, and benefits of the pelvic exam, and that I have had my questions answered.

Patient Name: ____________________________________ Date: ___________

Signature of parent/guardian/legally authorized representative, or patient over the age of 18: ____________________________________

Note: Minors that request examination & treatment for sexually transmissible disease may provide consent to such treatment in accord with FL Law

Note: If you are a minor, & your physician believes that you would suffer health hazards if maternal health & contraceptive information & services of a nonsurgical nature are not provided to you, your physician may provide such services to you without parental consent in accordance with FL Law

Sunshine Pediatrics Vaccination Policy

The providers in this office recommend the immunization schedule of the Centers for Disease Control and Prevention which is also the schedule endorsed by the American Academy of Pediatrics. There is no evidence that this immunization schedule is not in the best interest of most infants. However, the providers do understand that parents are concerned with giving so many vaccinations. As providers, we stress the importance of parents being informed of evidence-based healthcare information and safety for their child. It's our job to inform parents about available protection for your child against preventable diseases. Once we've done our best to inform parents, it's the parent's job to make decisions about their child's preventative healthcare. Because of our understanding of parents' concerns, if a parent is more comfortable following an alternate vaccine schedule, we are willing to work with the parents. We believe in informed choice, personal responsibility and respecting the parent’s decision.

THIS BEING SAID, be aware that we cannot falsify or violate FLORIDA LAW:

- If you choose not to vaccinate or to follow a delayed schedule, you must sign the American Academy of Pediatrics “Refusal to Vaccinate” form at each and every well child visit.
- We cannot give you a FL 680 form unless your child is completely up-to-date according to the CDC/AAP immunization schedule.
- We do not and cannot issue a medical exemption from vaccines unless we have clear scientific documentation of a medical exemption necessity.
- We do not and cannot issue religious exemptions. You must go to your county health department to be issued a religious exemption.
- PLEASE do not ask us to violate or falsify FLORIDA LAW. Pressuring us to violate or falsify FL law can result in your child(ren) being discharge from our care.

If you are doing a delayed or alternative schedule from the CDC/AAP’s recommended schedule, we can provide you with a 687 form which basically is a record of the vaccinations your child has received. This form is only a record; it is not FL 680 that certifies that the child is up-to-date on their vaccinations per CDC/AAP recommendations and State of Florida Regulations.

To further clarify the difference between a FL 680 form and FL 687 form: the FL 680 is certified by the healthcare provider that the child is up-to-date with the State of Florida Regulations (recommended schedule of the CDC/AAP), and the FL 687 is just a record of the vaccinations your child has received. Most daycare, pre-schools, public and private schools under State of Florida Regulations require the FL 680 and will not accept the FL 687.

I understand that Sunshine Pediatrics’ electronic medical record system automatically uploads your child’s immunizations record to Florida SHOTS system.

If it is the choice of the parent to decline or delay vaccines of the CDC/AAP schedule a parent must sign the American Academy of Pediatrics Refusal to Vaccinate Form (can be found on our website) each time a scheduled vaccine is declined. I further understand that this policy is non-negotiable and non-compliance will result in immediate discharged of the patient from the practice.

I also understand a copy of this policy is on the Sunshine Pediatrics’ website www.mysunshinepediatrics.com along with other information about Florida State Regulations, the CDC/AAP recommended immunization schedule and other helpful information regarding vaccinations.

I acknowledge I have read this policy and fully agree to abide by it.

Child’s name (print):____DOB_______________
Parent/Guardian Signature:____
Date:__________________

PATIENT HISTORY

PATIENT NAME: ______________________________ DOB: ______________________________

BIRTH HISTORY

ADOPTED? Y / N
MULTIPLE BIRTH? Y / N
HOSPITAL NAME: ______________________________
TERM (WEEKS): ______________________________
BIRTH WEIGHT: ______________________________
BIRTH LENGTH: ______________________________
BIRTH CONDITION (HEALTHY?): Y /N
PLEASE EXPLAIN IF NO: ______________________________
DELIVERY: C-SECTION / VAGINAL
BREAST MILK / FORUMLA (TYPE): ______________

ASSITED CONCEPTION? Y / N
GESTATIONAL DIABETES? Y / N
HIGH RISK PREGNANCY? Y / N
INDUCTION OF LABOR? Y / N
MATERNAL USE OF ALCOHOL? Y / N
MATERNAL USE OF DRUGS? Y / N
MATERNAL USE OF TOBACCO? Y / N
SURGERIES ON BABY? Y / N
CIRCUMCISION? (BOYS ONLY) Y / N
JAUNDICE? Y / N

FAMILY HISTORY

BIOLOGICAL MOTHER:
ALLERGIES: ______________________________
MEDICATIONS: ______________________________
HEALTH CONCERNS: ______________________________
DRUG/ALCOHOL USE: ______________________________
SMOKER? Y / N
SIBLING:
ALLERGIES: ______________________________
DEVELOPMENTAL DELAYS: ______________________________
ASTHMA? Y / N
ANEMIA? Y / N
OTHER: ______________________________
____

BIOLOGICAL FATHER:
ALLERGIES: ______________________________
MEDICATIONS: ______________________________
HEALTH CONCERNS: ______________________________
DRUG/ALCOHOL USE: ______________________________
SMOKER? Y / N
SIBLING:
ALLERGIES: ______________________________
DEVELOPMENTAL DELAYS: ______________________________
ASTHMA? Y / N
ANEMIA? Y / N
OTHER: ______________________________
____

EXTENDED FAMILY HISTORY
PLEASE LIST ANY FAMILY MEMBERS WITH THESE HEALTH CONCERNS

KIDNEY/LIVER DISEASE: ______________________________
STROKE: ______________________________
CANCER: ______________________________
ASTHMA: ______________________________
ALLERGIES: ______________________________
SUDDEN DEATH: ______________________________
DEVELOPMENTAL DISABILITY: ______________________________
SEIZURES: ______________________________

HIGH CHOLESTEROL: ______________________________
HIGH BLOOD PRESSURE: ______________________________
HEART PROBLEMS: ______________________________
DIABETES: ______________________________
HYPO/HYPER-THYROID: ______________________________
MENTAL ILLNESS: ______________________________
REFLUX: ______________________________
ANEMIA: ______________________________

OTHER: ______________________________

SOCIAL HISTORY

WHO LIVES IN HOME: ______________________________
SMOKERS IN HOME? Y / N

PETS IN HOME: ______________________________

WELL-VISIT POLICY

Date: ________________ Patient: ______________________________

The policy of this office is that your child needs to be current with all required well visits REGARDLESS of vaccination status as per the AAP schedule. Failure to keep any of the routine well visits will be cause for discharge from out practice. NO EXCEPTIONS.

The schedule will be given to you or you can access it on the AAP website.

Please see attached wellness visit schedule and CDC vaccination schedule. You can also access it on the CDC and AAP websites for further information.

We appreciate your cooperation with our policies as we strive to provide the best possible care for you child.

By signing below, I am stating that I have read and understand this notice.

Thank you,

Management/Sunshine Pediatrics

Signature_________________________ Print name______________________________

Sunshine Pediatrics of Central Florida, PL

Richard Rodrigues, M.D.

210 Lookout Place

Maitland, FL 32751

Phone: 407.215.0400 Fax 407.215.0402

<u>*KEEP FOR YOUR RECORDS*</u>

WELL VISIT SCHEDULE

BIRTH – NEWBORN VISIT (1-5 DAYS)

2 WEEKS

2 MONTH

4 MONTH

6 MONTH

9 MONTH

12 MONTHS

15 MONTHS

18 MONTHS

2 YEARS

30 MONTHS

3 YEARS

4 YEARS

ANNUALLY UNTIL AGE 18

These visits are recommended by the American Academy of Pediatrics (AAP) and this office for routine screening, disease prevention and wellness.