WELCOME TO SURFSIDE PEDIATRICS!

Carolyn Feltus-Atkinson M.D. and Teena Sanders APRN, CPNP welcome you to Surfside Pediatrics, a pediatric medical practice seeing patients from birth to 21 years of age.

Appointments

Together, Dr. Feltus and Teena see patients Monday through Friday. We ask that you arrive before your appointment time to fill out paperwork so that you are ready to be seen at your appointment time. We know your time is precious so a patient who arrives 15 minutes late for an appointment will be rescheduled so that the subsequent patients are not delayed. We ask that you give us 24 hours notice if you need to cancel an appointment so that other patients have an opportunity to be seen. There is a $25 no-show charge.

Hospital Coverage

Newborns in our practice are seen in the hospital by the neonatal service and if your child needs to be hospitalized, hospitalists from Florida Hospital for Children take care of admissions at Holmes Regional Medical Center. These hospital-based doctors will provide us with patient care updates and at time of discharge will help you to arrange follow up at our office.

Phone Calls

Please call during weekday business hours of 8-5pm for medical questions. We take lunch from 12:00 to 1:00 and are closed at noon on Thursdays. Calls after hours are relayed by the answering service which can be reached by contacting the office at 321-821-4882 and pressing #8. We ask that after-hours calls are reserved for emergencies only.

Insurance

We accept most major health insurances. Please present your insurance card to the receptionist at every visit and let us know if there has been a change in your coverage or your address since the last time you were seen. Copays are collected at the time of service.

Billing

Please direct billing questions to **SurfsideBilling@gmail.com** which is the new billing email or call (321) 802-4574. Emailing is preferred as it gives us time to review your concern and get back to you in a timely manner.

Online communication

Our website, www.SurfsidePedsFL.com, contains a lot of great information, forms and helpful links. Like us on Facebook—Surfside Pediatrics where we post articles and let you know what types of illnesses are in the community. Please do not ask medical questions on Facebook as we do not check it frequently. Please let us know if you have any questions or concerns.

Again, we welcome you to our practice!

150 5th Ave, Suite C, Indialantic, FL, 32903 • (321) 821-4882 • www.SurfsidePedsFL.com

CONSENT TO RELEASE MEDICAL RECORDS

Patient Name: _____ **DOB:** _____

Parent or Guardian: _____

I give permission for my (my child's) medical records to be released TO:

Name of Facility: _____

Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

FROM:

SURFSIDE PEDIATRICS
150 5th Avenue, Suite C
Indialantic, Florida, 32903
Phone: (321) 821-4882 Fax: (321) 312-4598

These medical records are required for the continuing treatment of this patient and are used in accordance with this facilities established privacy practices.

This disclosure should include:

☐ **ALL medical records**
☐ **SPECIFIC medical records (Please specify what medical records)**

_____

_____

I understand that this authorization is voluntary, and that I may revoke this authorization in writing at any time. I also understand that this signed consent will be valid for one year from the date indicated below.

Signed: _____ **Date:** _____

Print Name: _____

PATIENT REGISTRATION

Date: _____ **Reason for this visit:** _____
Last Name: _____ **First Name:** _____ **MI:** ____
SSN: _____ **DOB:** _____ **Sex:** ☐ **Male** ☐ **Female**
Address: (If P.O. Box, please provide street address also)
Street: _____
City: _____ **State:** _____ **Zip:** _____
Mother's Name: _____ **Father's Name:** _____
Preferred Email: _____
Parent's Marital Status: _____
Phone Numbers (Please list in order of preference and who the number belongs to)
(_____) _____ ☐ **Cell** ☐ **Work** ☐ **Home**
(_____) _____ ☐ **Cell** ☐ **Work** ☐ **Home**
(_____) _____ ☐ **Cell** ☐ **Work** ☐ **Home**
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Pacific Islander/Hawaiian Native ☐ White ☐ Decline to answer ☐ Other_____
Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Decline to answer

Medical Insurance

Primary: _____ **Secondary:** _____
Insurance Member/ID #: _____ **Group #:** _____
Policy Holder: _____ **SSN:** _____ **DOB:** _____
Address: _____
Relationship to Patient: _____
Emergency Contact: _____ **Relationship:**_____
Emergency Contact Phone: Home _____ **Cell**_____
May we leave a message on your answering machine? ☐ **YES** ☐ **NO**
Preferred Pharmacy (Include Phone/City/State) _____
Health Insurance Information:
A copy of your insurance card(s) will be scanned to your file. If proper insurance information is not provided on the date of service, you will be responsible for back charges. It is your responsibility to be aware of the medical benefits your insurance provides.

I understand that I am responsible for any bill I receive from the lab.

Parent/Guardian Signature: _____ **Date:** _____

PEDIATRIC PATIENT MEDICAL HISTORY FORM

Name: _____ **Child's Nickname:** _____ **Today's Date:**_____

Birth History

Birth Weight: _____ **Pregnancy #:** _____ **Mom's Age?** _____
Was the birth ☐ **Vaginal?** ☐ **Cesarean?** ☐ **Early?** ☐ **Late?**
If birth was early, how many weeks early? _____ **If Cesarean, why?** _____
Did mother have any illnesses/problems with her pregnancy? ☐ **Yes** ☐ **No**
If yes, please explain: _____
Did baby have any problems right after birth? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Before mother knew she was pregnant or at any time during her pregnancy did she:
☐ Smoke Cigarettes (Amount?) _____ ☐ Drink Alcohol (Amount?) _____
☐ Use "Street" Drugs (Type?) _____ ☐ Use Prescription Drugs (Type?) _____

Current and Past History

Does your child have any serious or chronic illnesses? ☐ **Yes** ☐ **No**
If yes, please explain: _____
_____
Has your child had any serious injuries or accidents? ☐ **Yes** ☐ **No**
If yes, please explain: _____
_____
Has your child had any surgeries? ☐ **Yes** ☐ **No**
If yes, please explain: _____
_____
Has your child ever been hospitalized? ☐ **Yes** ☐ **No**
If yes, please explain: _____
_____
Has your child ever reacted to immunizations? ☐ **Yes** ☐ **No**
If yes, please explain: _____
_____
Is your child up to date on immunizations? ☐ **Yes** ☐ **No**
If no, please explain: _____

SURFSIDE PEDIATRICS

Patient Name: _____ **Date of Birth:** _____

Social History

Household Information (Please list all those living in the child's home)

Name	Relationship to Child	DOB

Are there siblings not listed above? If so, please list their full names, ages, and where they live

_____

_____

_____

Smokers in household? ☐ **Yes** ☐ **No**

Is your child enrolled in daycare or school? ☐ **Yes** ☐ **No** Please list: _____

Does your child participate in regular exercise? ☐ **Yes** ☐ **No** Please list: _____

Does your child drink caffeine? ☐ **Yes** ☐ **No** Amount**:** _____

Is there a swimming pool at home? ☐ **Yes** ☐ **No** If yes, is it secured? ☐ Yes ☐ No

Are guns kept in the home? ☐ **Yes** ☐ **No** If yes, are they secured? ☐ Yes ☐ No

Are there any pets in the home? ☐ **Yes** ☐ **No**

If yes, please list the type: _____

Are there smoke detectors at home? ☐ **Yes** ☐ **No**

Are there fire extinguishers at home? ☐ **Yes** ☐ **No**

Are there carbon monoxide detectors at home? ☐ **Yes** ☐ **No**

Does the patient use seatbelts/car safety seats? ☐ **Yes** ☐ **No**

Does the patient use a safety helmet for riding a bike, scooter, skateboard, and roller skates/ blades? ☐ **Yes** ☐ **No**

Are there any issues/stresses for the family that we should be aware of? ☐ **Yes** ☐ **No**

If yes, please list: _____

SURFSIDE PEDIATRICS

Patient Name: _____ **Date of Birth:** _____

Family Medical History

Have any family members (Parents, Siblings, Grandparents, Aunts/ Uncles) had the following:

Alcohol/Drug Abuse	☐ **Yes**	☐ **No**	Who/What? _____
Allergies	☐ **Yes**	☐ **No**	Who/What? _____
Asthma	☐ **Yes**	☐ **No**	Who/What? _____
Birth Defects	☐ **Yes**	☐ **No**	Who/What? _____
Blood Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Bone Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Cancer	☐ **Yes**	☐ **No**	Who/What? _____
Diabetes	☐ **Yes**	☐ **No**	Who/What? _____
Endocrine Disease	☐ **Yes**	☐ **No**	Who/What? _____
Ear/Nose/Throat Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Eye Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Gastrointestinal Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Heart Disease	☐ **Yes**	☐ **No**	Who/What? _____
High Blood Pressure	☐ **Yes**	☐ **No**	Who/What? _____
High Cholesterol	☐ **Yes**	☐ **No**	Who/What? _____
Immune Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Joint Problems	☐ **Yes**	☐ **No**	Who/What? _____
Kidney Disease	☐ **Yes**	☐ **No**	Who/What? _____
Liver Disease	☐ **Yes**	☐ **No**	Who/What? _____
Lung Disease	☐ **Yes**	☐ **No**	Who/What? _____
Migraine Headaches	☐ **Yes**	☐ **No**	Who/What? _____
Metabolic Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Obesity	☐ **Yes**	☐ **No**	Who/What? _____
Seizure Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Skin Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Stroke History	☐ **Yes**	☐ **No**	Who/What? _____
Thyroid Disorders	☐ **Yes**	☐ **No**	Who/What? _____
Mental Health History	☐ **Yes**	☐ **No**	Who/What? _____
Other Medical History	☐ **Yes**	☐ **No**	Who/What? _____

CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ **DOB:** _____

Parent or Guardian: _____

I give permission for my (my child's) medical records to be released FROM:

Name of Facility: _____

Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

TO:

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Signed: _____ **Date:** _____

Print Name: _____

CONSENT TO TREAT

- ***ANY PATIENT UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT/GUARDIAN***
- ***PLEASE BE AWARE THAT IMMUNIZATIONS, PROCEDURES, OR WELL VISITS CANNOT BE PERFORMED WITHOUT THE PARENT OR LEGAL GUARDIAN***

☐ **ONGOING** ☐ **SPECIFIC DATE(S)** _____

I, the parent/legal guardian of _____ **hereby give permission to** _____

_____

to bring my child to Surfside Pediatrics for medical examination and treatment as necessary.

☐ **I decline to add any persons to seek medical treatment for my child.**

.....

ASSIGNMENT OF BENEFITS:
I authorize payment of medical benefits to Surfside Pediatrics for any services furnished. I understand that I am responsible for any amount not covered by my insurance carrier.

AUTHORIZATION FOR RELEASE OF INFORMATION:
I authorize Surfside Pediatrics to release information concerning health care, advice, treatment or supplied provided to me for the purposes of billing my insurance company, any medical professional involved in my present or future care and, if relevant, to my school athletic director, athletic trainer or sport's coach.

AUTHORIZATION TO TREAT:
I authorize Surfside Pediatrics to perform the treatments and/or procedures considered necessary for my wellbeing. I understand that such treatments and/or procedures will be clearly explained to me in advance. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

PRIVACY POLICY:
I understand that a copy of Surfside Pediatrics' **PATIENT BILL OR RIGHTS AND PRIVACY PRACTICES** are available in the waiting room, and that a personal copy of these documents is available in the front office upon request.

Signed: _____ **Date:** _____

Print Name: _____