Magnolia Pediatrics

Cancellation Policy

Magnolia Pediatrics wants to insure that each patient will receive the utmost quality care and that each patient can have regularly scheduled appointments according to their needs. Consequently, if you must cancel an appointment, we request that you provide our office with at least 24 hours notice. If you miss an appointment without calling ("NO SHOW") you will be charged $30.00. The $30.00 fee will be added to your account and due in full at the time of your next scheduled appointment. This is not covered by your insurance and will be your responsibility.

Thank you for understanding!

Signature:_____ Date:_____

MAGNOLIA PEDIATRICS

PATIENT HISTORY

NEWBORN HISTORY

Instructions: Complete only if child is less than 10 years of age. Advance to Childhood history if this section does not apply. This information is considered confidential.

Where was the child born? Hospital:_____ City/State:_____
Due Date:_____ DOB:_____
Did Mother receive prenatal care? YES/NO *(circle)*

Delivery type: Vaginal:____ C-section____

Were there any problems or complications during the Pregnancy or Delivery? YES/NO *(circle)*
If "YES", please describe:_____
_____

Birth Weight:_____lbs. _____oz. Length:_____
How many days was the child in the hospital? _____
Did mother smoke cigarettes during pregnancy? YES/NO *(circle)*
Consume alcohol during pregnancy? YES/NO *(circle)*
Drug exposure during pregnancy? YES/NO *(circle)*
Did this child have any problems during the first week of life? YES/NO *(circle)*
If "YES", please describe:_____
_____

CHILDHOOD HISTORY

Does this child have any recurring problems? YES/NO *(circle)*
If "YES", please describe:_____
_____

Is this child allergic to anything? YES/NO *(circle)*
If "YES", please describe:_____
What is the reaction? _____

Has this child seen a dentist? YES/NO *(circle)* Name of Dentist:_____

Any concerns with growth and development? YES/NO *(circle)*
If "YES", what concerns?_____
_____
Has this child had any surgeries or hospitalizations at any time other than birth? YES/NO *(circle)*
If "YES", please explain:_____
_____

CHILDHOOD ILLNESSES

Please circle all that apply for this child:

Measles	Mumps	Blood in Urine
Chicken Pox	Asthma	Skin Problems
German Measles	Nightmares	Fainting Spells
Pneumonia	Blueness(cyanosis)/Apnea	Head Injury
Rheumatic Fever	Poisoning	Ear Infections
Urine or Kidney Infection	Trouble Hearing	Other:_____
Seizures (with or w/out fever)	Anemia (low blood)	_____
Trouble Seeing	Easy Bruising	_____
Fractures/injuries	Tonsillitis	_____
Heart Murmur/Disease	Sickle Cell Anemia	_____
Blood Transfusion	High Blood Pressure	_____

FAMILY HISTORY

Please circle all that apply:

Diabetes	Sickle Cell Anemia	High Blood Pressure
Heart Disease	Leukemia	Seizures
Cancer	ALS/Neurological D/O	Thyroid Disorder
Death in First Yr of Life	Asthma	ADD/ADHD
Anemia	Behavior/Developmental	HIV
Arthritis	Lupus	

Household Exposure

Please circle all that apply:

Drugs	Tuberculosis	Domestic Violence
Smoke/Tobacco	Lead Poisoning	HIV

MAGNOLIA PEDIATRICS

PATIENT REGISTRATION

In order to serve you better, please fill out completely.

Date:_____ Patient's SS#:_____
Patient's Name:_____ DOB:_____ Male/Female
Mother's Name:_____ DOB:_____
Address:_____ Hm#:_____
City:_____ State:____ Zip:_____ Cell#:_____
Email:_____
Place of Employment:_____ Work#:_____

Father's Name:_____ DOB:_____
Address:_____ Hm#:_____
City:_____ State:____ Zip:_____ Cell#:_____
Email:_____
Place of Employment:_____ Work#:_____

Emergency Contact:_____ Phone#:_____
Relationship to Patient:_____

Names of Brothers/Sisters:
Name:_____ DOB:_____ Name:_____ DOB:_____
Name:_____ DOB:_____ Name:_____ DOB:_____

Primary Insurance:_____ ID#:_____
Subscriber Name:_____ Relationship:_____

Who are the legal guardians for this child?
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I authorize the following adults to bring the above named child to Magnolia Pediatrics for healthcare.

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I hereby authorize and consent to any and all medical care and treatment for the child named above which is deemed necessary and appropriate by the practitioners of Magnolia Pediatrics.

Signature:_____ Print Name:_____

Magnolia Pediatrics'
Privacy Notice

This notice is effective January 28, 2014. This notice will expire six (6) years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice and that it was explained to me.

_____		_____
Patient Name (Printed)		Date
_____		_____
Patient Signature	or	Parent of Child if Minor
_____		_____
Personal Rep (Printed)		Personal Rep (Signature)

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1. Complete Notice of Privacy offered/given to Patient {yes / no} (circle)
2. Patient refused/unable to sign Privacy Notice {refused / unable} (circle)

_____	_____
Signature (Registration Clerk)	Date

If refused, must be signed by two (2) witnesses.

_____	_____
Witness (Registration Clerk)	Witness
_____	
Date	

WELCOME TO MAGNOLIA PEDIATRICS

We are pleased that you have chosen Magnolia Pediatrics as your primary care provider. Stacey Cervantes, ARNP-C has been practicing in this community for over 20 years. Mrs. Cervantes graduated from the University of Florida. She is well known for her experience and compassion for her patients. In 2013, Neil Melvin, ARNP joined the staff. Neil has been a Pediatric Nurse Practitioner since 2003 and graduated from USF. He began his medical career as Registered Nurse working solely in pediatrics. Upon entering graduate school, Neil continued with his passion of pediatric medicine with a particular interest in ADHD and asthma while completing the Pediatric Nurse Practitioner program. With a combined effort they will continue to meet the healthcare needs of your child/children under the general supervision of Dr. Bilal Khodr, Board Certified Pediatrician.

We will be offering general pediatric care, including well exams, sports physicals, immunizations, visits for illness/injuries, as well as other general pediatric needs. As we provide the medical care you need, we the staff will be available to help you schedule appointments and understand our office procedures.

OFFICE HOURS

We will be open Monday through Friday 8am – 5pm, closing for lunch from 12:30pm – 1:30pm. Appointments can be made by calling 719-6500. Walk-Ins are not permitted but we will try to accommodate same day appointments as much as possible for urgent issues.

If an emergency arises after the office has closed or on the weekend, please call 911 or go to a local emergency room. If you need to speak with someone directly, you may call 719-6500, this number is not to cancel or make appointments after business hours.

Currently, in-patient care will not be provided in Lake City; however, referrals to specialty clinics and admissions will be made as needed.

INSURANCE/PAYMENTS

Currently we are accepting most insurance policies, with co-pays being expected **prior** to services rendered at each visit. We will be happy to file your claim with your carrier, however, please be aware that your insurance policy is basically a contract between you and your insurance company.