South Tampa Kids Pediatric Care
Patient Registration

Toni Glatchak, APRN, PNP-PC
3314 Henderson Blvd Suite 100B
Tampa | Florida | 33609
P: 813-801-KIDS (5437) F: 813-822-0296

PATIENT INFORMATION

Patient Name:	Gender: ☐ Female ☐ Male	DOB: _____ / ___ / ____
Patient Address: _____ _____	SSN: ___ ___ Preferred Language: E-mail address:	
Phone 1: ☐ Home ☐ Grandparent ☐ Mom Cell ☐ Mom Work ☐ Dad Cell ☐ Dad Work ☐ Other: _____	Race: ☐White | Caucasian ☐Black |African American ☐American Indian|Alaska Native ☐Asian ☐Native Hawaiian|Pacific Islander ☐Decline	
Phone 2: ☐ Home ☐ Grandparent ☐ Mom Cell ☐ Mom Work ☐ Dad Cell ☐ Dad Work ☐ Other: _____	Ethnicity: ☐ Hispanic|Latino ☐ Decline ☐ Not Hispanic|Latino	

GUARANTOR INFORMATION

First Guarantor:	Relationship to patient:
Guarantor Address: ☐ check if same as above _____ _____	DOB: / / SSN: - - Cell Phone:
Employer:	Work Phone: Extension:
Second Guarantor:	Relationship to patient:
Guarantor Address: ☐ check if same as above _____ _____	DOB: / / SSN: - - Cell Phone:
Employer:	Work Phone: Extension:

PHARMACY INFORMATION

Pharmacy Name: Pharmacy Phone:	Pharmacy Address: _____ _____

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy ID| Group Number:	Policy ID | Group Number:

EMERGENCY CONTACT

Name:	Relationship to patient:	Phone:

SIGNATURE

X	
Signature of Parent | Guardian | Responsible Party	Date Signed

I hereby authorize South Tampa Kids Pediatric Care to treat the patient listed above. I am aware this is a nurse practitioner led facility. I agree that balances are not covered by my insurance. I authorize the provider in the above-mentioned practice to provide full detail of my or my dependent medical history and treatment, including access to electronic pharmacy prescription records. In addition, I authorize the provider listed above to release any information necessary to assist in my medical treatment.

South Tampa Kids Pediatric Care
Family History Form
Today's Date: _____

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FAMILY HEALTH HISTORY FORM
PATIENT (S) INFORMATION

Patient Name:	DOB: ____ / ____ / _____

Previous Pediatrician Name, Address, Phone *(if applicable)*:

_____

_____

Are there specific concerns you wish to discuss? If so, please explain:

_____

BIRTH HISTORY

Birth weight:	Birth length:
Hospital | Facility:	Route: ☐ Vaginal ☐ Cesarean Section
Maternal | Fetal Pregnancy Complications:	
Maternal | Newborn Birth Complications:	

FAMILY HEALTH HISTORY

Select all that apply.	Mother	Father	Sibling	MGP	PGP	Other
Head: ☐headaches ☐cancer						
Eyes: ☐blindness cataracts ☐lazy eye						
Ear: ☐deafness ☐deformities ☐infections						
Nose | Throat: ☐sinus problems ☐tonsillitis ☐no smell						
Mouth: ☐cleft palate | lip ☐sleep apnea						
Heart: ☐congenital ☐heart attack ☐high blood pressure ☐murmur						
Lungs: ☐asthma ☐cystic fibrosis						
Stomach: ☐colitis ☐lactose intolerance ☐gastritis ☐ulcers						
Urinary: ☐congenital ☐kidney stones ☐infections						
Bone: ☐osteoarthritis ☐osteogenesis imperfecta ☐rheumatoid arthritis ☐scoliosis						
Neurological: ☐cerebral palsy ☐dysautonomia ☐paralysis ☐seizures ☐stroke						
Cancer(s) – specify:						
Developmental delay – specify:						
Psychiatric: ☐anxiety ☐bi-polar ☐depression ☐schizophrenia						
Other (thyroid disease, diabetes)—specify:						

South Tampa Kids Pediatric Care
Patient History Form

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PATIENT HEALTH HISTORY FORM

Patient Name:	DOB: ____ / ____ / _____

SAFETY | SOCIAL

Who lives at home?

Childcare | School situation: ☐ Daycare ☐ Preschool ☐ Nanny ☐ Elementary School or higher ☐ None of the above

Name of School/Preschool/Daycare:

If none, who cares for your child (ren) during the day?

Are there firearms at the home? ☐Y ☐N

Do you have a swimming pool at home? ☐Y ☐N

ILLNESS | SURGERIES

Have you been hospitalized for any reason? If yes, please explain. ☐Y ☐N

Have you had any surgeries? If yes, please explain. ☐Y ☐N

Have you been diagnosed with any major medical problems? If yes, please explain. Please list the name and specialist seen for the chronic medical condition(s). ☐Y ☐N

Have you had a history of any major illness (chickenpox, measles, guillian barre, etc.)? If yes, please explain. ☐Y ☐N

Have you had a history of fractures or traumatic brain injury? If yes, please explain. ☐Y ☐N

Other, please describe:

GENERAL HEALTH

Medications (*list name, dose, and frequency*) or attach form separately, if needed:

1.

2.

3.

4.

5.

Allergies (*medication, food, or environmental*):

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Patient History Form

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PATIENT HEALTH HISTORY FORM

Patient Name:	DOB: ____ / ____ / _____

REVIEW OF SYSTEMS

Select all that apply.
Head: ☐headaches ☐dizziness ☐traumatic brain injury ☐other:
Eyes: ☐blindness ☐cataracts ☐vision problems ☐infection ☐pain ☐other:
Ear: ☐deafness ☐deformities ☐infection ☐ pain ☐other:
Nose | Throat: ☐congestion ☐throat pain ☐lack of smell|taste ☐nose bleeding ☐loss of voice ☐ trouble swallowing ☐other:
Neck: ☐stiff neck ☐neck pain ☐swollen glands ☐other:
Mouth: ☐cleft palate | lip ☐tooth decay ☐poor bite ☐choking ☐snoring ☐mouth sores ☐other:
Heart: ☐chest pain ☐congenital heart disease ☐blue color ☐high blood pressure ☐murmur ☐shortness of breath ☐other:
Lungs: ☐asthma ☐cough ☐cystic fibrosis ☐pneumonia ☐other:
Stomach: ☐vomiting ☐diarrhea ☐constipation ☐abdominal pain ☐belching ☐flatulence ☐poop accidents ☐other:
Urinary: ☐congenital ☐kidney stones ☐infection ☐painful urination ☐frequent urination ☐bedwetting ☐other:
Bone: ☐pain ☐deformity ☐abnormal gait ☐osteoarthritis ☐osteogenesis imperfecta ☐rheumatoid arthritis ☐scoliosis ☐other:
Neurological: ☐cerebral palsy ☐dysautonomia ☐paralysis ☐seizures ☐stroke ☐meningitis ☐other:
Psychiatric: ☐anxiety ☐bi-polar ☐depression ☐schizophrenia
Endocrine, specify: ☐diabetes I ☐diabetes II ☐thyroid disease ☐cold|heat intolerant ☐hair loss ☐other:
Skin: ☐rash ☐infection ☐other:
Constitutional: ☐weight loss ☐weight gain ☐sleep disturbances ☐low energy ☐fever ☐other:
Hematological: ☐bleeding ☐bruising ☐anemia ☐bleeding disorder ☐other:
Cancer(s) – specify:
Developmental delay – specify:
Other – specify:

South Tampa Kids Pediatric Care
Billing Guidelines

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PATIENT INFORMATION

Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____

AUTHORIZATION

I understand that payment of medical services is due at the time of service.

I understand that the parent and/or legal guardian who signs this form is responsible for any and all payments of services including any unpaid balances. I am responsible for the costs incurred in the collection of any outstanding balances, including reasonable attorney fees and court costs.

I understand that if I am scheduled for a well child exam and other health concerns are brought up that would require a sick visit, I am responsible for the fee(s) or membership visit allotment incurred for both.

I am aware that I am financially responsible for any diagnostic testing and|or imaging that is ordered by the provider and may or may not be covered by insurance.

I am aware I have access to the office's Notice of Privacy Practices (listed at www.stkcare.com), which explains how protected health information will be used and|or disclosed.

I agree to update the practice if there are any changes to my insurance.

I understand that administrative fee(s) can occur for copies of medical records, completion of specialized forms (i.e. homebound, disability, FMLA paperwork), returned|declined credit card payment, non-urgent after hour calls, holiday calls, or "no-show" appointments.

SIGNATURE

Print Name & Relationship to patient:

X	
Signature of Patient | Parent | Guardian | Responsible Party I have read all the above information and understand/agree to all the provisions therein regarding my financial responsibility, permission for treatment, and notice of privacy practices.	Date Signed

South Tampa Kids Pediatric Care
Fee for Service

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FEE FOR SERVICE GUIDELINES

Well child appointment $150 & up

Sports Physical $100

Sick appointment $75 & up

Telehealth (virtual) appointment $50 & up

House Calls: $200 & up

After hour fee: $25 and up

In office services testing (included with membership only)

Blood Glucose: $10

Ear wax removal $10

Rapid COVID test: $35

Rapid Flu A|B test: $25

Rapid Flu A|B and COVID $55

Rapid Strep: $25

Rapid Mono: $35

Rapid RSV: $35

Stool sample for blood: $10

Urinalysis: $10

Urine HCG Pregnancy Screen: $10

South Tampa Kids Pediatric Care
Credit Card Authorization Form

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CREDIT CARD AUTHORIZATION

Cardholder Name (as it appears on card):	
Card Number:	
Expiration Date:	CCV2:

PATIENT INFORMATION

Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____

This authorization | consent will not expire unless the card on file has expired.

SIGNATURE

I hereby authorize South Tampa Kids Pediatric Care to charge the credit card listed above for payment of any outstanding charges at the point of care, within 48 hours of each visit date. This form will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may also revoke this form by emailing a written request with 30 days notice to info.stkcare@gmail.com. A new application must be submitted if the users credit card is expired, lost, or stolen. Please notify us immediately. I understand my card information will be kept in a secure encrypted format. I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact South Tampa Kids Pediatric Care for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with South Tampa Kids Pediatric Care and those attempts have failed.

Print Name:	
X	
Signature of Parent | Guardian | Responsible Party	Date Signed

South Tampa Kids Pediatric Care
Permission to Treat

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PERMISSION TO TREAT

I | We _____
print name(s) of legal guardian(s)

acknowledge, consent, and hereby authorize South Tampa Kids Pediatric Care and its affiliates to carry out your healthcare treatment today and in the future until revoked by writing. I also understand and give permission that medical care and treatment of my|our child|children will include, as determined by the health care practitioner, a full physical examination including an external genital examination. Additional treatments include, but are not limited to: the administration and performance of all treatments, the administration of any needed injections, the administration and use of prescribed medications, the performance of such procedures as may be deemed necessary or advisable for treatment, including but not limited to diagnostic procedures, the taking and utilization of cultures, and of other medically accepted laboratory tests, all of which in the judgment of your provider or their assigned designees may be considered medically necessary or advisable. You acknowledge and understand that this consent is given in advance of any specific diagnosis or treatment, that these services are voluntary, and that you have the right to refuse these services. You understand and intend this consent to be continuing in nature, even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving your revocation.

PATIENT (S) INFORMATION

Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____

SIGNATURE

Print Name:

X	
Signature of Parent | Guardian | Responsible Party	Date Signed

This authorization | consent will not expire.

WITNESS

Print Name:

X	
	Date Signed

South Tampa Kids Pediatric Care
Permission to Release Medical Information

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PATIENT INFORMATION

Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____

PERMISSION TO RELEASE MEDICAL INFORMATION TO

Name:	Relationship to patient:
Name:	Relationship to patient:
Name:	Relationship to patient:
Name:	Relationship to patient:

AUTHORIZATION (INITIAL ALL THAT APPLY)

_____	Access to all medical records and below topics.
_____	Access to all medical records excluding confidential files (i.e. mental health, HIV, STD, or pregnancy).
_____	Discuss my care with my provider.
_____	Discuss pharmacy | prescription records only.
_____	Schedule appointments (well, sick, or consultations).
_____	Receive orders and results for x-ray | radiologic imaging.
_____	Receive laboratory results (including HIV or other STD results).
_____	Other, please specify:

SIGNATURE

Print Name:

X	
Signature of Patient | Parent | Guardian | Responsible Party I authorize the above listed person(s) access to my medical information (specific approval access above). ***In the event I would like to append my authorization, it is my responsibility to update this information.***	Date Signed

