Pediatric Specialist

4950 S. LeJeune Rd.
Suite F
Coral Gables, FL 33146
(305) 665-3523 (p)
(305) 665-2272 (f)

New Patient Paperwork

Dear Parent,

Thank you for your interest in your child(ren) becoming a patient at Pediatric Specialist!

The following is what is needed in order for your child(ren) to become a patient at our practice:

1. Fill out the attached paperwork in its entirety and bring them to your scheduled appointment.
2. If your child(ren) is coming from another provider, be sure to fill out the *Medical Record Release Form* and we will forward it to the former provider on your behalf. Please note, we are unable to determine immunizations status at a well-child appointment without your child's previous records.
3. Call your insurance company to change your child's Primary Care Provider (PCP) to Gary M. Kramer, MD.
4. At your child's first appointment bring:
   a. Parent Photo ID/Driver's License
   b. Hospital or Former Provider Records
   c. Insurance Card for all Insurance Policies (Primary/Secondary/Tertiary).
   d. ***If you do not bring all of these items, your appointment may be rescheduled***.
5. We require the parent of the child to be present at the first appointment for the accuracy of all medical history and to sign our Consent to Treat Form.

NEWBORN APPOINTMENTS: Please be informed that we recommend accurate Insurance information, be given to us during the scheduling of your newborns first office visit appointment. Enrollment to the Insurance provided is highly important, as Payers grant a designated time frame for this process.

Due to Healthcare changes, there are certain Networks within Insurance Companies that do not grant us Participation.

If you have any questions or concerns regarding this information, please do not hesitate to call our office (305)665-3523.

Sincerely,
Pediatric Specialist

PATIENT INFORMATION

PATIENT NAME:____ ☐ MALE ☐ FEMALE

Last First Middle

PATIENT'S SOCIAL SECURITY #:__________________ AGE ___________ DATE OF BIRTH (DOB):_____________

ADDRESS:____ EMAIL:____________________

CITY/STATE/ZIP:______________________________ PHONE:______________ CELL:________________

PRIMARY INSURANCE:____________________________________ GUARANTOR:____________________

RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ BLACK/AFRICAN AMERICAN ☐ WHITE ☐ HISPANIC ☐ OTHER ☐ REFUSE TO REPORT

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ REFUSE TO REPORT

LANGUAGE: ☐ ENGLISH ☐ INDIAN (INCLUDES HINDI) ☐ SPANISH ☐ RUSSIAN ☐ OTHER__________________

PARENT(S) OR GUARDIAN(S) GUARANTOR INFORMATION

PARENT / GUARDIAN NAME:______________________________ SSN:______________ DOB: ___________

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER ____________________

ADDRESS:____________________________________ CITY/STATE/ZIP:____________________________

PHONE #:______________________ CELL:____________________ ☐ MALE ☐ FEMALE

EMPLOYER:__________________________________ OCCUPATION:______________________________

WORK ADDRESS:____ PHONE:____________________

INSURANCE:_________________________________ INSURANCE ID#:____________________________

INSURANCE ADDRESS: ____

PARENT / GUARDIAN NAME:______________________________ SSN:______________ DOB: ___________

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER ____________________

ADDRESS:____________________________________ CITY/STATE/ZIP:____________________________

PHONE #:______________________ CELL:____________________ ☐ MALE ☐ FEMALE

EMPLOYER:__________________________________ OCCUPATION:______________________________

WORK ADDRESS:____ PHONE:____________________

INSURANCE:_________________________________ INSURANCE ID#:____________________________

INSURANCE ADDRESS: ____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A RELATIVE OR FRIEND **AT A DIFFERENT ADDRESS**:

NAME:____ PHONE:______________________________

ADDRESS:_______________________________________ RELATIONSHIP TO PT:____________________

AUTHORIZATION TO LEAVE MESSAGES REGARDING PATIENT INFORMATION

I hereby authorize PEDIATRIC SPECIALIST (Gary M. Kramer, M.D., PA) to leave messages regarding testing results and scheduled appointments to the following

☐ HOME ☐ CELL PHONE NUMBER__________________ ________

(CHOOSE ONE)

INITIAL HERE

OTHER

MOTHER'S MAIDEN NAME:____

PREFERRED PHARMACY:____ PHONE NO:____

HOW DID YOU HEAR ABOUT US?:____

PLEASE GIVE THE RECEPTIONIST **ALL** INSURANCE CARDS AT EVERY VISIT

PEDIATRIC SPECIALIST
PARENTAL DESIGNATION FORM AUTHORIZING TREATMENT OF A MINOR

I ____, am the:
Print Parent/Guardian Name

☐ Natural or Adoptive Parent of

☐ Guardian of

☐ Person, who under court order, is authorized to give consent for

the minor: NAME:____ DOB_________________
Print Name of Minor Minor's DOB

I authorize PEDIATRIC SPECIALIST (Gary M. Kramer, M.D., PA), to discuss and provide medical treatment of the above named minor with the following authorized adult(s) who are over the age of 18 (ie: Grandparents, Siblings, Aunts/Uncles, Step-Parents, etc.):

NAME:_______________________________________ RELATION TO MINOR:_______________________ PHONE:____________________

NAME:_______________________________________ RELATION TO MINOR:_______________________ PHONE:____________________

NAME:_______________________________________ RELATION TO MINOR:_______________________ PHONE:____________________

NAME:_______________________________________ RELATION TO MINOR:_______________________ PHONE:____________________

NAME:_______________________________________ RELATION TO MINOR:_______________________ PHONE:____________________

NAME:_______________________________________ RELATION TO MINOR:_______________________ PHONE:____________________

____
SIGNATURE OF PARENT/GUARDIAN

____
DATE SIGNED