ORMOND PEDIATRICS

PATIENT REGISTRATION

Patient Information:

First Name:_____ Last Name:_____ D.O.B___/___/___ M/F

First Name:_____ Last Name:_____ D.O.B___/___/___ M/F

First Name:_____ Last Name:_____ _____ D.O.B___/___/___ M/F

First Name:_____ Last Name:_____ D.O.B___/___/___ M/F

Race _____ Ethnicity _____ Preferred Language_____

Address: _____ City_____ State___ Zip:_____

Home Phone: (___)_____-_____ Cell Phone: (___)_____-_____

Email:_____ Preferred Form of Contact (circle one) Home Cell Text Email

Parent/Guardian Information

Relationship (circle one) Mother Father Step Parent Grandparent Guardian

Name:_____ D.O.B ___/___/___ Social Security #:_____-_____-____

Address if different then above:_____ _____

Employer: _____ Work Phone (_____)_____-_____

Relationship (circle one) Mother Father Step Parent Grandparent Guardian

Name:_____ D.O.B____/___/_____ Social Security #:_____-_____-____

Address if different then above:_____

Employer: _____ Work Phone (_____)_____-_____

Insurance Information:

Primary Insurance:_____ Policy Holder:_____ DOB:_____

Member ID:_____ Group #_____

Name of adult (over 18 yrs of age) authorized to bring patient to appointments

Name:_____ Relation:_____ Phone: (_____)_____-_____

Name:_____ Relation:_____ Phone: (_____)_____-_____

Name:_____ Relation:_____ Phone: (_____)_____-_____

Pharmacy

Name:_____ Address:_____ Phone: (_____)_____-_____

I realize that I am responsible to pay any non-covered services and procedures. I hereby authorize the release of pertinent medical information to the insurance carriers.

Sign _____ Print_____ Date_____

PLEASE CONTINUE TO NEXT PAGE

Family & Social History

Is there anyone in the family (i.e parents, grandparents, aunts, uncles, cousins) with any significant conditions or illnesses (i.e. cancer, diabetes, heart disease, ect..)?

Known health problems	Mother	Father	Siblings	Grandmother	Grandfather	Aunt	Uncle	cousins
Alcohol and/or drug abuse								
Allergies								
Asthma								
Cancer								
Depression								
Diabetes								
Heart disease								
High blood pressure								
High cholesterol								
Mental illness								
Stroke								
Other								
Other								
Other								

Does anyone in the home smoke, consume alcohol, or use any other drugs? If so please list family member below.

Has the patient ever been hospitalized or had any surgeries? If so please list reason and dates below.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected Health Information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or health operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this content in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke the consent in writing at any time and all full disclosures will the cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send text to you to confirm appointment? YES NO

May we leave a message on your machine at home/cell? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____ _____

_____

This consent was signed by :(Print Name) _____

Signature _____ DATE _____

Please initial and sign the follow office policies.

Please arrive 10 minutes prior to your appointment time. This will allow our front office to fix insurance/ or update your chart.

Our office policy is that any patients that arrive 15 minutes after their appointment may need to be rescheduled. Initial here _____

If you are unable to make your appointment please call our office so that we may serve other patients that are in need of an appointment.

We are a PRO VACCINE office. If you chose not to vaccinate please find a new pediatrician.

Initial here_____

Definition of a NO-SHOW appointment is any scheduled appointment in which the patient either:

- Does not arrive to the appointment as scheduled.
- Arrives more than 15 minutes late and is consequently unable to be seen
- ** Please note three (3) NO-SHOW appointments will result in your discharge from the practice.

Initial here _____

Patient dismissal is at the discretion of the medical provider. If you are dismissed from the practice all remaining appointments will be cancelled.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. It is your responsibility to make sure that we have your current phone number.

Initial here _____

Cell Phone use in the patient rooms is strictly prohibited. The doctor requires your undivided attention.

Please note that video and photography in patient rooms is prohibited.

Initial here _____

I have read and understand the policies as described above and agree to its terms

_____ _____

Signature (Parent/ Legal Guardian) Relationship to patient

_____ _____

Print name Date