NEW PATIENT RESISTRATION

Patient Information:

Name: ______________________________ D.O.B___/___/___ M / F

Name: ______________________________ D.O.B___/___/___ M / F

Name: ______________________________ D.O.B___/___/___ M / F

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 from above:)________________________________

Employer:________________ Work Phone:________________

Cell Phone Number:________________

- Relationship: (circle one) Mother Father Step Parent Grandparent Guardian

Name: ________________ D.O.B___/___/___ Social Security #: ___-____-___

Address (If different from above:)________________________________

Employer:________________ Work Phone:________________

Cell Phone Number:________________

- Insurance Info: Primary Ins:____________ Policy Holder:____________
  D.O.B__/___/___ Member ID:____________ Group #:____________
- **Name of Adults OVER THE AGE OF 18 authorized to bring patient to appointments:**

Name:________________ Relation:____________ Phone:____________

Name:________________ Relation:____________ Phone:____________

Name:________________ Relation:____________ Phone:____________

- Preferred Pharmacy:________________ Address:________________

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:________

Family & Social History:

Is there anyone in the family (I.E Parents, Grandparents, Aunts, Uncles, Cousin) with any significant conditions of illnesses (I.E Cancer, Diabetes, Heart Disease, Etc..)

Known Health Problems	Mom	Dad	Siblings	Grandmother	Grandfather	Aunt	Uncle	Cousins
Alcohol and or Drug abuse								
Allergies								
Asthma								
Cancer								
Depression								
Diabetes								
Heart Disease								
High Blood Pressure								
High Blood Pressure								
High Cholesterol								
Mental Illness								
Stroke								
Cancer								
Other								

- **Does anyone in the home Smoke, Consume Alcohol or use any other drugs? If so please list family member(s) below.**

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- **Has the patient ever been hospitalized or had any surgeries? If so please list reason and approximate date below.**

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Sign:____________________ Print: ____________________ Date:__________

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 consent 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 information.
- 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 practice has the right to revoke 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 you a text to confirm your appointment? YES NO

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

May we discuss your medical condition/Information with any member of your family?

YES NO

If YES please name family members below:

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____

____

Sign:______________________ Print: ______________________Date:________

Ormond Pediatrics Office Policies

(Please Initial next to the office policy)

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.** **Initial here ________**
- **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 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**

  Initial here ________
- **Please note THREE 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 canceled.** **Initial here ________**
- **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 provider requires your undivided attention.** **Initial here_______**
- **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 their terms.

Relation to patient:____

Sign:______________________________ Print: ______________________________Date:_________