



Ormond Pediatrics

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.

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

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 seenInitial 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: _____