New Patient Registration Form

Ocean Pediatric care

10580 Spring Hill Drive, Spring Hill,FL,34608

PATIENT DEMOGRAPHICS

Today's Date:____/___/_____

Patient Last Name:_____ __First Name: ___ _____

Patient Date of birth:___/___/_____ Sex: Male / Female Home

Address:_____ _____City:_____State:_____

Zip:_____Cell: (_____)_____-_____Primary email: _____

BEST phone number to reach parents: 1.) Name:____ _____ (_____)___-_____

_____home/cell

Race: Asian / African American / Caucasian / American Indian / Native Hawaiian / Hispanic / other: _____

Ethnicity: Non-Hispanic / Hispanic / Refused to report Language preference: English / Spanish / Other:_____

Pharmacy Name:_____Address:_____Phone:_____ How did you hear about us? _____

Do you agree to receive periodic messages from the practice (appointments, labs results, Rx) Voice: Text:

FATHER

Father Last Name:_____DOB:____/___/_____ First Name: _____

Address:_____ City: _____State:_____Zip:_____ Best Phone #: (_____)_____-_____cell / work / home Alternate Phone#: (_____)_____-_____cell/work/home Email: _____

Occupation:_____

Employer:_____

MOTHER

Mother Last Name:_____DOB:____/___/_____

First Name: _____

Address:_____

City:_____State:_____Zip:_____

Best Phone #: (_____)_____-_____cell / work / home

Alternate Phone#: (_____)_____-_____cell/work/home

Email:_____

Occupation:_____

Employer:_____

Biological Parents Marital Status: Married / Single / Divorced / Widowed Other:_____

If divorced, who has custody of child?_____Who does the child Primarily live with: _____ Any court documents documenting custody of this child? YES / NO If yes, please provide copies for our records

If Step Parents please list names Step-Mom:_____Step-Dad:_____

INSURANCE	EMERGENCY CONTACTS
Primary Insurance: _____	Name:_____
Full name of Insured:_____	Relationship:_____Phone:_____
Subscriber ID:_____	May this person seek medical care for your child? YES / NO
Group#:_____	Name:_____
Subscriber DOB:___/___/_____Effective date: _____	Relationship:_____Phone:_____
Relationship to Patient:_____Co-pay $:_____	May this person seek medical care for your child? YES / NO

Does your child have any communication needs? Vision impaired / hearing impaired / Cognitive Issues
Does your child receive therapy / counseling /services (speech, ENT, allergy) from any other providers? YES / NO
If yes, please complete below:
Reason:_____Provider:_____Office Phone(__)__-_____

Medical History ;
Birth History; Full term _____, Preterm_____. Gestational age_____
Type of Delivery ; Normal vaginal delivery or Cesarean section ; Reason;
Birth weight; _____ Birth Height _____. Any complications at or after birth_____.

General Health: excellent good fair poor
Past Medical Illnesses: such as Asthma, Heart problem ,Allergies ,Type 1DM, Kidney Problem ,ADHD, Anxiety, depression or others_____ ,accidents, broken bones, other serious injury -

Allergies (Asthma,Eczema,Hay fever), Drug allergies _____ food allergies _____
anemia or bleeding disorder_____

Are his/her immunizations up to date? yes no When was his/her last dental visit?_____ *Please bring immunization record to first appointment.

Past Surgical history;_____Approximate years _____
Allergies to any Medication: (list medication and reaction): _____
_____
Family History: Is your child Adopted _Yes NO_____
Please list medical history for biological relatives:

Please list everyone who lives in the home with this child and note relationship:
Name: Age: Relationship: _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
Brothers/sisters and parents not living in the home:
Name: Age: Relationship: _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
Does your child get along well with her/his siblings? . . . . . yes no

Family History

	Mother	Father	Sibling	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Diabetes							
Hypertension							
Heart Disease							
Allergy food/other							
Anemia							
Asthma COPD							
Bleeding disease							
Depression							
Anxiety							
ADHD/ADD							
PTSD							
Bipolar							
Autsim							
Behavioral problem							
Stroke							
Cancer							
Autoimmune disease							
Seizures disorder							

Authorized Consent to Seek Medical Care

I am providing my current insurance information along with my copayment or full payment for the services rendered. I also understand if Rainbow Pediatric Center is unable to obtain payment from my insurance company I am responsible for payment in full for services rendered to my child/children while under the care of the above named person.
**Copay must be paid by the authorized adult bringing the child in for services or a $5 fee will be charged.

Patient Name _____/_____/_____ Patient's date of birth

Parent / Legal Guardian Signature _____/_____/_____ Date

For patients 18 years and older ONLY: Patient listed above may present and be treated unaccompanied by an adult. Yes__No_____(parent, please initial one)

If you are allowing someone other than the parents to bring in the child (grandparents, nanny, aunt/uncle, etc. in case parents are at work or out of town), please complete and sign below

I (Parent / legal guardian),_____am hereby giving permission for the following person to bring my child/children to Ocean Pediatric Center and to receive medical treatment and advise during my absence.

Name:_____DOB:___/___/_____Relationship:_____ Name:__DOB:___/ /_____Relationship:_____ Name:_____DOB:_____/_____/ _____Relationship:_____

Please specify dates: From_____/_____/_____to_____/_____/_____(ex. 18th birthday or the week you will be out of town and child with grandparents)

We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify Rainbow Pediatric Center of a divorce, legal separation, change in custody arrangement, or any other circumstances which may alter this Authorization.

OFFICE FINANCIAL AGREEMENT:

AUTHORIZATION OF ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF MEDICAL RECORDS

Please read carefully and sign stating that you understand and agree with our policies

**** Please note both parents have access to child's information, unless a court order is on file****

I understand payment of all medical care is due at the time of service. We accept cash, check, visa, master card and Discover. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for Treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that if my account is not paid in full by my insurance within 60 days of the date of service, I am responsible for payment in full. I understand that, in case of default, I am responsible for any costs incurred in the collection of patient account, as well as reasonable attorney fees and court costs**.**

Your insurance requires you to pay your co-pay at every visit and we incur an expense in billing for these small balances. Therefore, we find it necessary to charge this fee.

Returned checks are subject to a service charge of **$40.00** and you will lose your privilege to write checks in our office**.**

Missed appointments: **Ocean Pediatric Center** requires 24-hour advance notice for all cancellations. Failure to notify our office will result in a **$15.00** fee. Emergencies will be considered on a case-by-case basis for waiver of this fee. After the third no show, the patient will be discharged from the practice.

Medical Records: There will be a charge of **$1.00** per page for the first 25 pages and **$.50** thereafter for the copying of medical records. For FMLA or military forms there will be a $20 fee. Physical and immunization forms are provided free of charge at your child's annual well visit. There will be a $5 fee per form for records requested after your child's well
visit. These records require a minimum of 24hrs to complete. If you need these sooner you may pay an additional $5 fee per form to get the form completed in <4hrs. For sports physicals, in order to complete forms, your child MUST have had a well visit in our office in the last 3 months or a sports physical visit must be completed.

Medical Forms: Physical and Immunizations forms are PROVIDED FREE at your child's yearly well visit. If needed after please allow our office 2-3 business days to complete.

Newborns: *If you are enrolling your baby to an insurance policy please be sure to do so within 30 days of birth*. As a courtesy we will hold claims for 30 days prior to submitting to the insurance allowing you this time to add the baby. Please note: Our office visits are not billable under mother's coverage. Baby must be added as an individual policy holder.

Ocean Pediatric Center only bills **ONE** insurance policy. If your child/children are covered by two policies, we will only bill the primary insurance.

Deliquent Bills: On a case-by-case basis Management will work with Responsible Party to address delinquent accounts. **If unresolved, the account will be assigned to external collection agency. I will also be responsible for all additional financial charges levied.**

Guarantor Name:_____Patient Name**:**_____

Signature:_____ **Date:**_____/_____/_____

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION "Notice of Privacy Practices"

I hereby give consent to Ocean Pediatric care and all health care providers furnishing care within the practice to use and disclose health information for the purposes of treatment, payment and health care operations.

I further authorize Ocean Pediatric. to furnish information from my medical records as requested by other physicians or medical care facilities, hospitals or home health agencies for my continued care and treatment or for peer review activities.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe information may identify me.

I understand that I have a right to request Ocean Pediatric care to restrict how they use and disclose my protected health information for the purposes of treatment, payment or health care operations.
Ocean Pediatric care. is not required to grant my request, but if they do, the restriction will be binding on Ocean Pediatrics

I acknowledge that I have received the Notice of Privacy Practices for Ocean Pediatrics which provides more detailed information about how Ocean Pediatric care may use or disclose by protected health information.

Father's Printed Name

Mother's Printed Name

Father's Signature

Mother's Signature

Date

Date

Acknowledgement of Office Policies

Date:_____/_____/_____

By initialing each of the statements below ***I have been given a copy of Ocean Pediatrics Office policies brochure*** and understand each of the policies.

_____Informed of office hours of operation and office locations.

_____Informed that only medical questions or concerns should be made after office hours to on-call provider.

_____Call back time for phone triage non-emergent calls is 6hrs & urgent messages within 2 hours during office hours.

_____Informed of website information www.Oceanpediatric.com

_____Informed about Facebook page as way to receive most current information

_____Informed that the patient portal is secure and I may sign up to obtain access to my child's medical information.

_____Informed that Vanderbilt questionnaires should be completed PRIOR to wellness exams from age 4mo – 6 years & ADD/ADHD appointments to provide valuable developmental screening for my child.

_____Informed that prescription refills require at least 48hrs to process.

_____Informed that referrals take 5 business days to process from date of visit referral requested.

_____Informed that I must complete a records release in order to get old records from previous providers and to send my child's medical record to another provider. Outgoing records take 3-4 business days to process request.

_____Informed that I must always come to the office with insurance card and must pay co-pays or co-insurance at the time of the visit. It is my responsibility to understand my insurance and what it covers.

_____ **You will be asked to sign a vaccine refusal form for any vaccines that are not received or staggered but recommended at the visit.**

_____Informed that I will receive a copy of my child physical and immunization record at each wellness exam. If I request additional forms will take a minimum of 48hrs to complete.

_____Informed that if my child has not had their most recent wellness exam within 3 months that I will be asked to schedule a sports physical to complete sports physical, camp or other specialty forms.

_____Informed that providers may request follow-up for my child and that these appointments are important to keep to ensure my child's recovery from illness.

_____Informed ADD/ADHD visits are required every month. Refills will not be issued if not done. Medication cannot be refilled sooner than 28 days. We will not combine wellness exams, sports physicals, etc. with ADD/ADHD appointments.

_____Informed that our office requires pre-op exam 2-3 days prior to surgery. This may be in addition to surgeon's policy.

_____Informed that our office requires a 24hr notice for all cancellations or reschedules.

_____Informed that any patient arriving more than 15 minutes late may be asked to wait.

_____Informed that any child under age 17yr MUST be accompanied by an adult. No immunizations can be given without a parent present.

Patient name:_____Date of birth:____/___/_____Relationship to patient:_____

Name of guardian:_____Guardian Signature: _____

Medical Records Release Authorization

To whom it may concern:
I hereby authorize the release of my child's medical records, or copies of such, and request that they be transferred from your office to Ocean Pediatric Center at the contact information below as soon as possible.

Ocean Pediatrics
10580 spring hill drive, spring hill fl 34608 Ph: 352-835-7110 Fax: 352-835-7111

Please NO discs. We prefer faxed or printed copies.

Previous Provider Information
Office Name: _____

Address:_____City: _____

State: _____ Telephone: (_____)_____- _____ Fax: (_____)_____- _____

Check the reports to be disclosed:

□ Complete Records	□ Immunizations	□ Lab Results	□ Growth Charts
□ Radiology Reports	□ Operative Reports	□ Consultations	□ Summary of Visits

Below is my child's information for the records that I am requesting: ONLY ONE CHILD PER FORM

Name:_____ DOB:_____/_____/ _____

Reason for Requested use or Disclosure: □Change in Healthcare Provider □Legal □Personal use □2nd Opinion
□Other:_____This authorization expires in 6 months from the date signed or earlier if needed:___/___/___

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- The practice will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely and under no pressure from any individual to do so.
- Information disclosed under this authorization might be re-disclosed by the recipient & this re-disclosure may no longer be protected by federal/state law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
- This authorization may include disclosure of information relating to alcohol and drug use, and confidential HIV related information only if I check this box and write my initials beside □ __
- If I am authorizing the release of HIV related, alcohol, or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV relation information without authorization.

Parent's Name :_____ Relationship to child: _____

Parent's Signature:_____Date:_____/_____/_____Phone:_____