Patient Registration Forms

Your child's health is of the utmost importance to us. Please fill out all forms completely and as accurately as possible. If you are unsure of how to complete any portion of these forms, please ask a staff member and we will be happy to assist you. All information is confidential.

Today's Date: _____

Patient's Name: _____
First Middle Last

Patient's Date of Birth: _____

Patient's Phone #: _____

Patient's Social Security Number: _____

Mailing Address: _____

_____
City State Zip Code

Race: _____ Ethnicity: _____ Language: _____

Preferred Pharmacy:
CVS / Winn-Dixie / Walgreens / Wal-mart / Jay's / O'Quinn's
City of Pharmacy location: _____ Phone #: _____

Siblings: (Brother(s) / Sister(s) – Please include their age)

_____

_____

Mother's / Guardian's Name: _____ Primary Guardian: Yes / No
Relationship to Patient: _____ Responsible for Patient's Bill: Yes / No
Date of Birth: _____ SSN: _____
Home Phone: _____ Employer: _____
Cell Phone: _____ Work Phone: _____
Email: _____
Address (if different than patient): _____

Father's / Guardian's Name: _____ Primary Guardian: Yes / No
Relationship to Patient: _____ Responsible for Patient's Bill: Yes / No
Date of Birth: _____ SSN: _____
Home Phone: _____ Employer: _____
Cell Phone: _____ Work Phone: _____
Email: _____
Address (if different than patient): _____

Office Use Only: Patient ID: _____ **Information Entered by:** _____

Health History/
Patient Registration Forms

Information Release:

Little Pine Pediatrics considers all patient information confidential. Please list all individuals other than patient's Parents and Grandparents who are authorized to bring your child to the office to be treated. This also gives us authorization to discuss any medical condition, test results, treatment plans, etc. with this person.

1. Full Legal Name: _____

   Relationship to Patient: _____

2. Full Legal Name: _____

   Relationship to Patient: _____

3. Full Legal Name: _____

   Relationship to Patient: _____

Insurance Information:

Person Responsible for Patient's Account: _____

Relationship to Patient: _____

Date of Birth: _____ SSN: _____

Mailing Address: _____

_____

City State Zip Code

Insurance Carrier: _____

(Ex: BCBS / UHC / Aetna / Medicaid / Prestige / Staywell-Wellcare / CMS)

Policy #: _____ Group #: _____

Claims Address (located on back of insurance card):

_____

Insurance Phone #: _____

Copays and Co-insurances are due at time of service. We accept Credit/ Debit Cards, Cash and Checks.

Office Use Only: Patient ID: _____ **Information Entered by:** _____

Health History/
Patient Registration Forms

Patient Medical Information: (Drug (Medication) / Food / Other Allergies)
1._____
Type of Reaction: _____
2. _____
Type of Reaction: _____
3._____
Type of Reaction: _____

Current Medications: **(**Please include name of medication and directions for its use.)

Name of Medication: _____
Directions: _____
Name of Medication: _____
Directions: _____
Name of Medication: _____
Directions: _____

Does your child have any of the following medical conditions? Circle all that apply

Acid Reflux	Bipolar Disorder	Cancer	High Blood Pressure	Low Blood Pressure
Asthma	ADHD/ADD	Constipation	Immune Deficiency	Migraines
Allergies	OCD	Heart Problems	Diabetes	Seizures
Anemia	Depression	Nose Bleeds	Sinus Problems	Hypothyroid

Other: _____
Please explain any conditions circled above: _____
_____
Surgeries (Please include year performed):
_____
Family Medical Problems (Biological & Grandparents): _____
_____

Social History: (Please circle all that apply)
Water Type: City / Well / Nursery / Bottled
Smoking Status: None / Inside Only / Outside Only / Both
Guns in the Home: None / Locked / Dual Locked / Unlocked (optional)

Office Use Only: Patient ID: _____ **Information Entered by:** _____

Health History/
Patient Registration Forms

Review of Systems:
Please circle all that apply to your child now or in the recent past:

General:	Recent Weight Loss	Recent Weight Gain	Weakness	Fever
Head:	Headache	Head Injury		
Eyes:	Visual Change	Redness	Drainage	
Ears/Nose:	Ear Pain	Ear Drainage	Nasal Congestion	Nose Bleeds
Mouth/Throat:	Sore Throat	Sores in Mouth		
Neck:	Swollen Glands	Mass on Neck		
Respiratory:	Cough	Wheezing	Short of Breath	
Cardiac:	Chest Pain	Rapid Heart Beat		
GI:	Nausea/Vomiting	Diarrhea	Stomach Pain	
Urinary:	Frequent Urination	Pain w/ Urination	Blood in Urine	
Lymph/Herne:	Swollen Glands	Easy Bruising	Excessive Bleeding	
Endocrine:	Excessive Thirst	Excessive Hunger	Excessive Sweating	
Psychiatric:	Nervousness	Depression	Anxiety	

If there is anything else that you would like to comment on that was not asked above please do so here:

_____

_____

_____

Previous Provider: _____
City & State: _____
Phone #: _____

Acknowledgement of Little Pine Pediatric Policies:
Please sign below stating that you have read and understand the following policies displayed in the waiting areas:

- Privacy Notice
- Appointment Policy
- Financial Policy
- Vaccine Policy

Signature of Parent/Guardian: _____ Date: _____

Office Use Only: Patient ID: _____ **Information Entered by:** _____

LittlePinePediatrics PLLC

Uses for Disclosure of Protected Health Information

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information.

Print Name: _____

Social Security Number:_____ DOB:_____

Little Pine Pediatrics may share my child's health information on the information listed below for the purpose of:

x	Physician Referral	x	Legal
x	Insurance		Other
Explain other:			

I request that the following health information be shared:

x	Entire Little Pine Pediatrics medical record

The following sensitive information must be specifically initialed to be included:

	HIV/AIDS related records		Mental health records/information
	HBV or TB related records		Domestic violence
	Other communicable disease		Drug or alcohol diagnosis/treatment*
	Genetic information/testing		

*Federal regulations require a description of what kind of information and how much is to be disclosed. Explain:_____

I understand that, if a person or entity that receives my personal health information is not a health care provider or health plan the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient is prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.The person I am authorizing to use and/or disclose the information may not receive compensation for doing so.I also understand that I may refuse to sign this authorization and my refusal to sign will not affect my capacity to obtain treatment or payment of eligible benefits. I understand that I may revoke this authorization in writing at any time except to the extent that has taken place up to the date of the revocation notice or unless a specific date is listed below:
Authorize disclosures up to _____ , 20_____.
This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient or Parent/Guardian: _____Date: _____

Little Pine Pediatrics PLLC

Confidential Communications Request

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine or voice mail system.

However, it should be noted that our current Notice of Privacy Practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s).

Print Patient's Name: _____ DOB: _____

Address: _____

City, State & Zip Code: _____ Phone: _____

I consent for detailed messages to be left on:

My home answering machine	
My cell phone	
With my spouse	
Other:	

☐ I do not consent for detailed messages to be left on any answering machine or voice mail; I prefer to be contacted personally at this number: _____.

☐ I do not consent for any documentation to be sent to my address on record, I prefer correspondence to be mailed to: _____.

This will remain in effect until you rescind it in writing.

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient: _____ Date: _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____

LittlePine

Authorization for consent of Medical Treatment

I, _____ grant permission to Little Pine Pediatrics Medical Providers to perform necessary medical treatment for the persons listed below in the event I, the parent or guardian cannot be contacted through reasonable efforts when need for treatment is immediate. I do hereby indemnify and hold harmless Little Pine Pediatrics.

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Parent or Guardian (please print): _____

Parent or Guardian Signature: _____

Relationship to patient: _____ **Date:** _____

Address:

_____

Phone Number: _____

Staff Signature: _____ **Date:** _____

Please circle which office you would like your records released to.

Perry Office
1702 S. Jefferson St.
Perry, FL 32348
P (855)-577-5437
F (855)-815-8083

Madison Office
194 NE Hancock Ave
Madison, FL 32340
P (850)-253-2275
F (850)-253-2280

Alachua Office
15260 NW 147th Dr. Ste 200
Alachua, FL 32615
P (386)-518-0102
F (386)-518-0116

Dr. Ronald Emerick, D.O.
www.littlepinepediatrics.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ DATE OF BIRTH:_____

I authorize _____ in _____to release

(Previous Provider) (County, City & State or Phone #)

the health information of the above named individual to _____.

(New Provider or Person)

I understand that the information in my health record may include immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.

INFORMATION TO BE DISCLOSED:

____Complete Record - List Reason:_____

____H & P, Discharge Summary ____Test Results

____Operative Report ____Consultation

____Other – Specify:_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I also understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. This will expire one year from the date of the authorized signature.

_____ _____

Signature of patient or legal representative Date

_____

Relationship – if signed by legal representative

_____ _____

Signature of Witness Date