PEDIATRIC PARTNERS OF ZEPHYRHILLS, PA

6712 Dairy Rd
Zephyrhills, FL 33542
Office: (813)782-6064
Fax: (813)782-0984
www.ppzdocs.com

Today's Date: _____

PATIENT INFORMATION ☐ New Patient ☐ Existing Patient

Patient's Last Name: _____ **First:** _____ **MI**___
Date of Birth: ___/___/_____ **Patient's SSN:** ___-___-_____ Sex: ☐ M ☐ F
Home Address: _____
City: _____ State: ____ Zip: _____

PARENT/GUARDIAN INFORMATION
Who is responsible for the patient? **Parent:** ___ **Grandparent:** ___ **Other:** ___

PRIMARY FAMILY EMAIL: _____
PRIMARY FAMILY PHONE: (_____) _____-_____

PARENT/GUARDIAN Last Name: _____ **First:** _____ **MI**___
Relation to patient: _____
SSN: ___-___-_____ Date of Birth: ___/___/_____
Home Address: _____
City: _____ State: ____ Zip: _____
Mobile Phone: (_____) _____-_____ **Work Phone**: (_____) _____-_____
Employer: _____

PARENT/GUARDIAN Last Name: _____ **First:** _____ **MI**___
Relation to patient: _____
SSN: ___-___-_____ Date of Birth: ___/___/_____
Home Address: _____
City: _____ State: ____ Zip: _____
Mobile Phone: (_____) _____-_____ **Work Phone**: (_____) _____-_____
Employer: _____

Alternate Contact:
Last Name: _____ **First:** _____ **MI**___ Relation to patient: _____
Alternate contact #: (_____) _____

Preferred language
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Patient's Ethnicity:
- ☐ Unknown
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to answer

Patient's Race:
- ☐ American indian or Alaskan native
- ☐ Asian
- ☐ Black or African American
- ☐ Hawaiian native or Pacific Islander
- ☐ White
- ☐ Decline to specify

FORM COMPLETED BY:
Name (print) _____ **Signature** _____ **Date** _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST
PAYMENT FOR PROFESSIONAL SERVICES IS DUE & PAYABLE WHEN SERVICES ARE RENDERED

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Today's Date: _____

PATIENT HEALTH HISTORY

Patient's Last Name: _____ **First:** _____ **MI**___
Date of Birth: ___/___/_____
Medication Allergies: _____
Non - Medication Allergies: _____

Prenatal/Delivery history
Maternal problems during pregnancy: _____
Type of delivery: ☐ Vaginal ☐ C-section, specify reason: _____
Any complications during labor/delivery? ☐ No ☐ Yes, specify: _____

Birth weight: ___lbs ___ oz Birth length: ____ in Hospital: _____
☐ Full-term ☐ Pre-term (less than 37 weeks), specify: _____

Did the newborn leave the hospital with the mother? ☐ Yes ☐ No
If no: why? _____
Any problems as a newborn? ☐ No ☐ Yes, specify: _____

Chronic medical problems: _____
Surgeries: _____
Hospitalizations: _____
Are Immunizations up to date: ☐ Yes ☐ No, specify: _____

Family history **(as relating to the patient being seen, ex: mom, dad, bro, sis, mom's dad, dad's dad, mom's bro)**

Allergies _____
Birth defects _____
Cancer _____
Diabetes _____
Heart disease _____
Other _____

Asthma _____
Mental retardation _____
Mental illness _____
Seizures _____
Thyroid _____

Social history
Child's parent's ☐ married ☐ together ☐ separated ☐ divorced
Sibling names: _____
Lives with: _____
Attends daycare? ☐ No ☐ Yes, name of daycare: _____
Attends school? ☐ No ☐ Yes, name of school: _____
Pets: ☐ No ☐ Yes, what type : _____
Smokers: ☐ No ☐ Yes, specify: _____
Parent's occupation:
Mother: _____
Father: _____

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INSURANCE INFORMATION

Primary Insurance Plan: _____ Secondary Insurance Plan: _____

Policy Holder Name: _____ Policy Holder Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy #:_____ Policy #:_____

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefit to be paid directly to Pediatric Partners of Zephyrhills, PA. I understand and agree that, regardless of my insurance status, I am ultimately responsible for any professional services rendered.

_____ _____

Signature of responsible party Date

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical information for insurance carriers or for continuing patient care.

_____ _____

Signature of responsible party Date

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary for the patient named above.

_____ _____

Signature of responsible party Date

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Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations and Acknowledgement of Receipt of Notice of Information Practices

I understand that as part of my health care, Pediatric Partners of Zephyrhills, PA originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serve as:

- ☐ A basis for planning my care and treatment
- ☐ A means of communication among the many health professionals who contribute to my care
- ☐ A source of information for applying my diagnosis and surgical information to my bill
- ☐ A means by which a third-party payer can verify that the service was instilled or actually provided
- ☐ And a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosure.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the Practice reserves the right to change their notice and practices and that prior to implementation it will mail a copy of any revised notice to the address that I have provided.

I understand that I have the right to object to the use of my health information for the directory purposes.

I understand that I have the right to see and obtain copies of my medical record.

I understand that I have the right to request amendments be made to my medical record.

I understand that a 6-year history of all disclosures will be accessible to me including the purpose of disclosure and the address of the recipient. I may receive a copy of this history within 60 days of my request and I understand that I have to pay a reasonable charge of $1 per page after the first requested in a 12 month period.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations and the Practice is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

Patient's name: _____
Date of birth: ___/___/_____

_____ _____ _____
Signature of patient or legal representative | Relationship to patient | Date