

## **New Patient Packet**

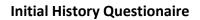
## **Patient Information**

Patient Name:	Sex: Male/Female			
Date of Birth:/	Social Security Number:			
Patient Address				
	StateZip			
Phone Number:	Email:			
Father's Name:	Date of Birth//			
Marital Status:SingleMarriedWidov	wedDivorced SS#			
Father's Employer:	Occupation			
Father's Phone Number	(Circle One) Cell Home Work			
Is Mother responsible for the Bill if Insuran	ce fails to pay part or all? (Circle One)YesNo			
Mother's Name	Date of Birth//			
Marital Status:SingleMarriedWidov	wedDivorced SS#			
Mother's Employer:	Occupation			
Mother's Phone Number:	(Circle One) Cell Home Work			
Is Father responsible for the Bill if Insurance	e fails to pay part or all? (Circle One)YesNo			
Insurance Information Primary Insurance Co. Name:				
	Date of Birth			
	Group #:			
	·			
	Date of Birth			
Policy/Contract #:				
Emergency Contact				
Name	Phone#:			
Relationship to Patient/Parents:				
Other Children in Family:	<del></del>			
Signature of Responsible Party:				
Printed Name:				



## Consent Form Medication History Acknowledgment

l,	, understand that my Physician or my child's Physician may need
	y work in conjunction with my pharmacy and /or insurance carrier in
order to provide accurate medical treatment	t.
Signature of Responsible Party:	Printed Name
Preferred Pharmacy:	
	City
Medical Treatment and Release of Individua	l Health information
I give permission to release health information	on necessary to my child's treatment and the processing of insurance claim
to the following:	
1. Billing Services	
2. Individual Insurance companies	
3. Physicians associated with patient care	
4. Hosptial lab and procedural departments	
5. Agencies associated with patient care	
6. Companies providing electronic health rec	cord services
Please list any family members , relatives, sig	gnificant others who may obtain health information or records on your
behalf. Also list anyone who may obtain me	dical treatment and health information on your child's behalf.
Name:	Relationship
Insurance release/ assignment of benefit/pa	yment authorization
Your fee for services is due and payable by c	ash, check, credit or debit card at the time of treatment. We may not
participate in all insurance plans and if your	plan is one in which we do not participate, please ask for an office receipt
so you can file for reimbursement. Regardle	ess of any insurance, the guarantor is responsible for his/her bill. The
guarantor will also be responsible for all cha	rges incurred by collection agencies or past due accounts.
Signature of Responsible Party	Printed Name





Patient Name:		_ DOB:/	/ Age Today:Years_	Month
Form Completed by:		Today's Date		
Household Information: Please list those living in the o	child's home:			
Name	Relationship to Child	AGE	Health Problems	
rtuire	relationship to child	7.02	Treater Francisco	
	ing with your?) If so, list their nam			
Name	Relationship	Age	Place of Residence	
	the baby born at term?or Any prenatal or neonat		Delivery:Vaginal s?	
*Was a NICU stay required? I	f so, please explain:			
Use drugs or other med	erUse TobaccoDrin			
	FormulaBreat Milk Hov	-		
*Did your baby to home with	mother from the hospital?	YesNo	Details	
General				
* Do you consider your child t	to be in good health?YesN	o If no explain:	·	
* Does your child have any se	rious illness or medical conditions	?YesNo	If yes explain:	
*Has your child had any surge	erv? Yes No Explain			
	spitalized?Yes No Explain			
	nedicaitons?YesNo Explair			
	gh to eat? Yes No Explain			



## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the use or disclosure of my protected health information (PHI) as described. I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations. Patient Name: \_\_\_\_\_DOB\_\_\_\_\_SS#\_\_\_\_ I hereby authorize Decatur Morgan Pediatrics to \_\_\_release to and/or \_\_\_obtain from the following information pertaining to my treatment: Release to or Obtain from: Name: Phone Fax Release or Obtain the following Information: \_\_\_\_Progress Notes \_\_\_\_History & Physical \_\_\_\_Lab \_\_\_Immunization Records \_\_\_\_Discharge Summary \_\_\_\_\_Pathology Report \_\_\_\_Referrals \_\_\_\_Imaging Report Other Entire Medical Record The purpose for this disclosure?\_\_\_\_\_ Please Fax records to: 256-973-5865 or mail to: Decatur Morgan Pediatrics 1215 7th Street SE Decatur, Al 35601 I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services for alcohol or drug abuse. I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used on disclosure as provided in CFR164.524. If I have questions about disclosure of my health records, I may contact the Health Information Director at 256-973-6175. REVOCATION: This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken. Said revocation is to be presented to the Medical Records Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the information will expire on the following date, event or condition: If I fail to specify an expiration date, event or condition this authorization will expire in 6 months from the date of signing. It is often necessary to release your health information via fax or other electronic submission when it is needed for continuing care. We confirm receipt of information when it is faxed. I authorize transmission of my health records in situations where this information is needed for continuing care. I understand that as the recipient, I am responsible for the security of these medical records copies and the health information contained therein, whether in paper format or a CD/DVD Signature of Patient /Representative:\_\_\_\_\_\_\_Date\_\_\_\_\_\_ Relationship to Patient?\_\_\_\_\_ Witness Signature:\_\_\_\_\_

Date