

Patient History and Information Form for 2012

Patient's Name _____ Today's Date _____ DOB _____ SS# _____ M _____ F _____

Home Address _____ City/State/Zip _____

Hm Phone _____ Primary # Y ___ N ___ Parent's Cell _____ Primary No# Y ___ N ___ Email _____

Child's Cell No# (if over 13 yrs) _____

Would you like to receive our electronic monthly newsletter at the email address provided above? _____ Yes _____ No

Name of School _____

Siblings _____ DOB _____ SS# _____

_____ DOB _____ SS# _____

_____ DOB _____ SS# _____

_____ DOB _____ SS# _____

Father's Name _____ DOB _____ Drivers Lic# _____ State _____

Address (if different from pt) _____

Father's Home Phone _____ Primary No# Y ___ N ___ Cell _____ Primary No# Y ___ N ___ Work _____ SS# _____

Father's Employer _____ Phone # _____

Mother's Name _____ DOB _____ Drivers Lic# _____ State _____

Address (if different from pt) _____

Mother's Home Phone _____ Primary No# Y ___ N ___ Cell _____ Primary No# Y ___ N ___ SSN# _____

Mother's Employer _____ Phone # _____

Primary Insurance Company _____ Co-Pay _____ Effect Date _____

Policy Holder _____ ID Number _____ Grp # _____

Receipt of Notice of Privacy Practices Form

I, _____ hereby acknowledge receipt of Physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

- 1. I give Pediatric Partners permission to leave lab/test results information on our home voice mail _____ yes _____ no
- 2. I give Pediatric Partners permission to fax any and all protected health information regarding my child for prescription refills, school/camp forms, medical records, school/daycare notes, immunization records, referral forms _____ yes _____ no
- 3. Pediatric Partners has my permission to disclose medical information to the following individuals:

Name: _____ Relationship : _____

Name: _____ Relationship : _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient:

I have read the above policy regarding Receipt of Notice of Privacy Practices Form and I agree to the terms. By way of signature below I agree that the information provided above is true and accurate information.

Printed Name: _____ Date: _____

Signature: _____ Relationship to Patient _____