Original

CHILDREN'S CLINIC OF PENSACOLA, P.A.

Mylene Victoriano, MD, FAAP

Ronald Victoriano, MD, FAAP

NEW PATIENT FORM

PATIENT

Name (Last, First, MI)	Social Security	Age	Date of Birth	Sex	Home Phone

PARENT/LEGAL GUARDIAN

Name (Last, First, MI)	Social Security	Age	Date of Birth	Sex	Home Phone

Mailing Address	City	State	Zip Code	Cell Phone

Employer	City	State	Zip Code	Work Phone	Email

INSURANCE INFORMATION

Primary Insurance Company	Subscriber's Name	Relationship to Child	Policy Number	Co pay
	Date of Birth	Social Security	Group Number	
		Effective Date of Policy	Deductible	
Secondary Insurance Company	Subscriber's Name	Relationship to Child	Policy Number	Co pay
	Date of Birth	Social Security	Group Number	
		Effective Date of Policy	Deductible	

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicaid) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I permit a copy of this release to be used in place of the original.

Signature: ______________________________ Date: ______________________________
(Signature of insured or authorized person, or parent if minor)

Patient's Name: ______________________________

EMERGENCY CONTACT INFORMATION (other than parent)			
Name	Relationship	Home Phone	Cell Phone

Family/ Guardian Information		
Mother	Date of Birth	Best Contact Phone
Occupation	Employer	Work Phone
Home Address	City & State	Zip Code
Father	Date of Birth	Cell / Home Phone
Occupation	Employer	Work Phone
Home Address	City & State	Zip Code
Guardian	Date of Birth	Cell / Home Phone
Occupation	Employer	Work Phone
Home Address	City & State	Zip Code

I hereby authorize the following people to seek medical treatment for my child in my absence:

Name: ______________________ Relationship: __________ Phone__________

Name: ______________________ Relationship: __________ Phone__________

Name: ______________________ Relationship: __________ Phone__________

Name: ______________________ Relationship: __________ Phone__________

Name: ______________________ Relationship: __________ Phone__________

CHILDREN'S CLINIC OF PENSACOLA, P.A.

MEDICAL HISTORY FORM

Date: ____________

Child's Name: ________________________________ **Date of Birth:** ____________________

Birth History:

Birth Weight: ___________ ❒ Full-Term ❒ Premature, # weeks: _______ ❒ Boy ❒ Girl
❒ Vaginal ❒ C/ Section, due to: ________________________
Hospital Name/State: ______________________________
Pregnancy concerns? ❒ No ❒ Yes (Please explain)
____

____

Any medical problems with your newborn after delivery? ❒ No ❒ Yes
Please describe any newborn problems: ______________________________

____

Specialty Care:
Has your child ever seen a medical specialist? ❒ No ❒ Yes (Please explain):
____

____

Past Medical History:
Does your child have a history of any medical conditions? ❒ No ❒ Yes (please circle any that apply)

Genetic: chromosome abnormality other: ____________
Neurologic: seizures migraines concussion head trauma other: ____________
Respiratory: asthma BPD croup pneumonia seasonal allergies other____________
Cardiac: heart murmur VSD ASD other: ____________
Gastrointestinal: constipation acid reflux liver disease pyloric stenosis other: ____________
Urology: urinary tract infections urinary reflux kidney disease enuresis other:____________
Muscle/Bone: club foot hypotonia scoliosis other:____________
Dermatology: eczema acne warts molluscum hemangioma other: ____________
Infectious: tuberculosis HIV meningitis ear infections strep throat other: ____________
Heme/Onc: anemia leukemia cancer other: ____________
Behavior/Mood: ADHD anxiety obsessive/compulsive depression other: ____________
Development: delay-speech/language delay-motor skills autism other: ____________
Learning: special education dyslexia other: ____________
Speech: articulation/speech therapy other: ____________
Hearing: ear tubes hearing loss other: ____________
Vision: lazy eye blurred vision astigmatism cataract other: ____________

Additional Details: ______________________________________

Hospitalizations: ❒ none
Date: ____________ due to: ______________________
Date: ____________ due to: ______________________

Surgeries: ❒ none
Date: ________ due to: ______________________
Date: ________ due to: ______________________

Current Medications: ❒ none
(name) (dose)
____
____
____
____

Allergies: ❒ none known
(Name and reaction)
Medication: ______________________
Food: ______________________
Pets: ______________________
Seasonal: ______________________
Indoor: ______________________
Latex: ______________________

Family History:

Other Children (names/ages):

______________________ ______________________

______________________ ______________________

Please list any family medical conditions:

Mom: ____
Dad: ____
Sister/Brother: ____
Grandparents: ____
Cousins: ____

Care/Education:

❒ home ❒ day care ❒ pre-school ❒ school-grade _____ ❒ home school ❒ college

Home Environment:
Parents: ❒ married ❒ single/live together ❒ single-parent ❒ divorced

Smokers: ❒ no ❒ yes -- ❒ inside ❒ outside
Home Type: ❒ house ❒ apartment
Pets: ❒ no ❒ yes – type? ______________________

Please describe any other specific concerns you would like to discuss regarding your child?
____

How did you find out about our practice?
____

CHILDREN'S CLINIC OF PENSACOLA, P.A.
909 Garden Gate Circle
Pensacola FL 32504
477-5475

MEDICAL RECORDS TRANSFER REQUEST

Patient Name: ______________________ **Date of Birth:** ________________ **Telephone:** __________________

I authorize the following organization to release information as detailed below from the patient health information record:

Information to be Released From:	Information to be Released To:
	Children's Clinic of Pensacola, P.A. 909 Garden Gate Circle Pensacola FL 32504 Fax No: 477-8186

For most ***Healthy*** children, we will not require the complete medical record from your previous health care provider. We suggest initially:

Limited transfer of Medical Records to include the following information:

- Problem List, Medication List, Allergies
- Chart Notes for past ***12 months***
- Vaccination record, Growth charts
- Outside Notes/Correspondence
- Laboratory & Radiology Reports

If your ***Child has more Complex Medical Problems***, please check box, to request for his or her ***complete*** medical record.

☐ ***Complete*** Medical Record

We will review your child's outside medical record.

My signature below indicates my consent to authorize any physician, nurse, other health professional or an authorized representative to release any/all medical information and/or records that may be requested regarding patient health information.

________(Initial) I authorize the release of psychiatric/psychotherapy records, mental health records and drug/alcohol treatment records under the same conditions.

My signature below authorizes Children's Clinic of Pensacola, PA, or an authorized representative, to receive photocopies of all medical records, charts, notes and other information relating to the general physical condition of the patient listed above. I authorize release of this information to the above location for the purpose of continued medical care; and I allow them, or any physicians appointed by them, to examine this information. I understand that this consent is subject to revocation at any time by notification in writing, except to the extent the Children's Clinic of Pensacola PC has already acted in reliance of this release.

______________________ ______________________ ______________________
Signature Date Relationship to Patient

Prohibition of Re-disclosure. The information is being disclosed to you from records whose confidentiality is protected by state laws, specifically Florida Statutes 395.3025, 455.667 and 394.459. State Laws prohibit you from any further disclosure of this date without the specific written consent of the person to whom it pertains, or as otherwise permitted by Florida state statutes and regulations. A general authorization is not sufficient for this purpose.

CHILDREN'S CLINIC OF PENSACOLA, P.A.

ACKNOWLEDGEMENT OF RECEIPT
Privacy and Consent Agreements

By signing this Acknowledgement of Receipt, I declare that I have read, I understand and consent to abide by all the terms of the agreements as listed in the Privacy and Consent Agreements.

____

Parent/ Legal Guardian (Print)

____

Signature (parent/legal guardian)

____

Relationship to patient

____

Date

____

Patient's Name

CHILDREN'S CLINIC OF PENSACOLA, P.A.

OTHER IMPORTANT OFFICE POLICIES:

1. We are encouraging our patients to give us at least 24 hours notice if you are unable to come to your appointment. If you NO SHOW 3 times without informing our clinic, then your child will be discharged from the clinic. We also encourage our patients to comply with their appointments to specialists.

2. Please inform our clinic if there are any changes in your address, phone numbers or any contact information. Please provide our office with any changes in guardianship or insurance information.

I hereby certify that I have read, understood and agree with the above policies.

PATIENT'S NAME	DATE	PARENT/GUARDIAN'S SIGNATURE

ACKNOWLEDGEMENT AND CONSENT

I understand that the Children's Clinic of Pensacola, P.A. (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that this Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my health care and treatment, refer to, consult with and coordinate among and manage along with other health care providers for my care and treatment.
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care, and perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care including confirming appointments in advance and leaving that information on voice mail or answering machine.

I also understand that I have a right to receive a written description of how this Practice will handle health information about me. This written description is known as the **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other personnel of this Practice and my rights regarding my health information.

I understand that the Notice of Privacy practices may be revised from time to time and that I am entitled to receive a copy of any revised **Notice of Privacy Practices.**

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy practices, and I understand that this Practices is not required by law to agree to such requests.

By signing below, I agree that I reviewed and understand the information above and that I have read a copy of the Notice of Privacy Practices.

Date

____

First Name ______________________ **Last Name** ______________________ **Date of Birth** ______________________

Parent/Guardian Name:

____

Patient Parent/Guardian/Representative Signature

[Signed] - Date: 12/03/20 10:14:08 AM

Description of Representative's Authority

____

CHILDREN'S CLINIC OF PENSACOLA, P.A.
Ronald Victoriano, M.D.
Mylene Victoriano, M.D.

CONSENT TO TREATMENT

I do hereby authorize and request the performance of medical evaluation and treatment services for my child and the use of whatever procedures the physicians may deem necessary for treatment. I understand that the physicians and the assistants that they may designate to treat my child will use clinical and patient management techniques that are reasonable, necessary and advisable. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by Children's Clinic of Pensacola. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation or treatment at Children's Clinic of Pensacola. **I also authorize the administration of Immunization or Vaccinations** scheduled for Preventive Well Visit as required by the American Academy of Pediatrics and ACIP.

I understand that by signing this consent form, I am giving my consent to you to use and to disclose my protected health information as described in the Notice of Privacy practices to carry out treatment, payment activities and healthcare operations.

Today's Date

____

First Name ______________________ **Last Name** ______________________ **Date of Birth** ______________________

Parent/Guardian Name

____

Patient/Guardian/Representative Signature: