Mylene Victoriano, MD, FAAP Ronald Victoriano, MD, FAAP

NEW PATIENT FORM

Name (Last, First, MI)	t, First, MI) Social Security		rity	Age	Date of Birth		Sex	Home Phone	
PARENT/LEGAL GUA	RDIAN	Social Secu	rity	Age	Date of Birth	······································	Sex	liome Phone	***************************************
Name (Last, First, MI) Social								1.000.170.00	
Mailing Address		City		State	Zip Code	<u> </u>	Cell Phone		
and the second		P14. /		T State	Zip Code	Work Pl			
Employer		City		State	2ip Code	Work P!	one •	Email	
INSURANCE INFORM	ATION		·····		etterrinisterioriste tillitation tillitation tillitation tillitation tillitation tillitation tillitation tilli	a ar indiagh in an anna dhaarin in inigi			-
Primary Insurance Company	Subscriber's	Name		Relationshi	p to Child		Policy No	imber	Co pa
						1	•		
	Date of Birtl	<u></u>	erakusasan kan perintu kan Perintu kan perintu kan pe	Social Secu	rity		Group Ni	umber	
				Effective D	ate of Policy		Deductib	le	
Secondary Insurance Company	Subscriber's Name			Relationship to Child			Policy Number		Co pa
	Date of Birth		and a second delice to the second se	Social Security		-	Group Number		
				Effective D	ate of Policy	***************************************	Deductil	ble	
Patient Release: I certify the information t insurance claims to insura claims. I authorize payme	ince compar	nies or the	ir agencies	s (Including	Medicaid) for	purpose o	of filing	and payment of	of medic
original.								1000 m	
Signature:						ranger or consequences again the survey of			

CIME WORLD IACT COLLINGS	INFORMAT	TON (other that	n parent)		
lame	Relationship		Home Phone		Cell Phone
		and the second s	****		
Family/ Guardian Info	ormation			1 2 - 2	
Mother		Date of Birth		Best Contact Phone	
Occupation		Employer		Work Phor	1e
Home Address	and the second s	City & State		Zip Code	
Father	T F	 Pate of Birth		Cell / Home	Phone
Occupation		mployer		Work Phone	
Home Address		City & State		Zip Code	
Guardian		Date of Birth		Cell / Hon	ne Phone
Occupation	and the second s	Employer		Work Pho	ne
				Zip Code	
Home Address		City & State		Inp cour	
anna ann an t-aire ann an an ann an ann an ann an an an an					
				· 6	abild in my absonce.
I hereby authorize th	e following	people to seek i			
		Relationship		***************************************	Phone
Name:					
Name:			Relationship:	Markette and the second	Phone
					PhonePhone
Name:			Relationship:	***************************************	*

MEDICAL HISTORY FORM

Birth History: Birth Weight:	*
Birth Weight:	
□ Vaginal □ C/ Section, due to: Hospital Name/State: Pregnancy concerns? □ No □ Yes (Please explain) Any medical problems with your newborn after delivery? □ No	
Any medical problems with your newborn after delivery? No Please describe any newborn problems:	ПУас
	L) 163
Specialty Care: Has your child ever seen a medical specialist? No Yes (Ple	ease explain):
Past Medical History: Does your child have a history of any medical conditions? Genetic: chromosome abnormality other: Neurologic: seizures migraines concussion head trauma Respiratory: asthma BPD croup pneumonia seasonal Cardiac: heart murmur VSD ASD other: Gastrointestinal: constipation acid reflux liver disease purology: urinary tract infections urinary reflux kidney disease Muscle/Bone: club foot hypotonia scoliosis other: Dermatology: eczema acne warts molluscum hemang Infectious: tuberculosis HIV meningitis ear infections Heme/Onc: anemia leukemia cancer other: Behavior/Mood: ADHD anxiety obsessive/compulsive de Develor mental leukemia delay maneral del	other:
Learning: special education dyslexia other: Speech: articulation/speech therapy other:	MANAGEMENT AND
Hearing: ear tubes hearing loss other:	ther:

(name) (dose) (Name and reaction) Medication:	Hospitalizations: 🗖 none	Surgeries: none
Current Medications:	Date: due to:	
(name) (dose) (Name and reaction) Medication:	Date: due to:	Date: due to:
Pets: Seasonal: Indoor: Latex:		(Name and reaction)
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?		Medication:
Seasonal:		Poter
Family History: Other Children (names/ages): Please list any family medical conditions: Mom:		Concernal:
Family History: Other Children (names/ages): Please list any family medical conditions: Mom:		Indoor
Please list any family medical conditions: Mom:		Latex:
Other Children (names/ages): Please list any family medical conditions: Mom:		
Please list any family medical conditions: Mom:	Family History:	
Other Children (names/ages): Please list any family medical conditions: Mom:		
Mom:	Other Children (names/ages):	
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-dinside outside Home Type: house apartment Pets: no yes-type?		
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-dinside outside Home Type: house apartment Pets: no yes-type?	Please list any family medical conditions	
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?		
Grandparents:	Mom:	
Care/Education: home	Mom:	
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?	Mom: Dad: Sister/Brother: Grandparents:	
Home Environment: Parents:	Mom:	
Parents:	Mom: Dad: Sister/Brother: Grandparents: Cousins:	
Parents:	Mom: Dad: Sister/Brother: Grandparents: Cousins: Care/Education:	
Smokers: ☐ no ☐ yes - ☐ inside ☐ outside Home Type: ☐ house ☐ apartment Pets: ☐ no ☐ yes - type?	Mom: Dad: Sister/Brother: Grandparents: Cousins: Care/Education: home day care pre-school	
Home Type:	Mom:	school-grade Dhome school College
Home Type:	Mom: Dad: Sister/Brother: Grandparents: Cousins: Care/Education: home day care pre-school Home Environment:	school-grade Dhome school College
Pets: Ono Oyes-type?	Mom: Dad: Sister/Brother: Grandparents: Cousins: Care/Education: home day care pre-school Home Environment: Parents: married single/live toge	school-grade home school college
Please describe any other specific concerns you would like to discuss regarding your child?	Mom: Dad: Sister/Brother: Grandparents: Cousins: Care/Education: home day care pre-school Home Environment: Parents: married single/live toge Smokers: home pose-dinside of	school-grade home school college ther single-parent divorced
	Mom: Dad: Sister/Brother: Grandparents: Cousins: Care/Education: home day care pre-school Home Environment: Parents: married single/live toge Smokers: how yes - inside of Home Type: house papartment	school-grade home school college ther single-parent divorced

909 Garden Gate Circle Pensacola FL 32504 477-5475

MEDICAL RECORDS TRANSFER REQUEST

Patient Name:	Date of Birth:	Telephone:
I authorize the following organ		detailed below from the patient health information
Information to be Released Fr	7274	formation to be Released To:
	Ch	ildren's Clinic of Pensacola, P.A.
		Garden Gate Circle
	1	nsacola FL 32504
		x No: 477-8186
For most <i>Healthy</i> children, we We suggest initially:	will not require the complete me	dical record from your previous health care provider.
Limited transfer of Me	dical Records to include the follo	wing information:
Problem List,	Medication List, Allergies	
Chart Notes I	or past 12 months	
 Vaccination r 	ecord, Growth charts	
Outside Note	s/Correspondence	
Laboratory &	Radiology Reports	
If your Child has more Complex	Medical Problems, please check b	ox, to request for his or her complete medical record.
☐ Complete Medica	Record	
We will review your child's ou	tside medical record.	AND THE STATE OF T
representative to release any/information. (Initial) I authordrug/alcohol treatment record	all medical information and/or ize the release of psychiatric s under the same conditions.	sician, nurse, other health professional or an authorized records that may be requested regarding patient health professional or an authorized records that may be requested regarding patient health professional patient health records and professional p
photocopies of all medical rec patient listed above. I authori	ords, charts, notes and other info ze release of this information to my physicians appointed by the on at any time by notification i	cola, PA, or an authorized representative, to receive ormation relating to the general physical condition of the the above location for the purpose of continued medica m, to examine this information. I understand that this n writing, except to the extent the Children's Clinic of
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.

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)	
or to the state of	
Signature (parent/legal guardian)	
Relationship to patient	*
Date	
Patient's Name	

OTHER IMPORTANT OFFICE POLICIES:

- We are encouraging our patients to give us at least 24 hours notice if you are unable to come to your appointment. If you <u>NO SHOW 3 times</u> 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.
- 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.

PATIENT'S NAME	DATE	PARENT/GUARDIAN'S S	GNATURE

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

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/Representa	tive Signature		
		T I	
[Signed] - Date: 12/03/20 10:14:08 AN	1	AND THE RESERVE OF THE PROPERTY OF THE PROPERT	
Description of Representative's Auth	nority		

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.

Last Name	Date of Birth
	Last Name