

CHILDREN'S CLINIC OF PENSACOLA, P.A.

Mylene Victoriano, MD, FAAP

Ronald Victoriano, MD, FAAP

**NEW PATIENT FORM**

<b>PATIENT</b>					
Name (Last, First, MI)	Social Security	Age	Date of Birth	Sex	Home Phone

<b>PARENT/LEGAL GUARDIAN</b>					
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

<b>INSURANCE INFORMATION</b>				
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: \_\_\_\_\_  
 (Signature of insured or authorized person, or parent if minor)

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION (other than parent)**

Name	Relationship	Home Phone	Cell Phone

**Family/ Guardian Information**

<b>Mother</b>	Date of Birth	Best Contact Phone
Occupation	Employer	Work Phone
Home Address	City & State	Zip Code
<b>Father</b>	Date of Birth	Cell / Home Phone
Occupation	Employer	Work Phone
Home Address	City & State	Zip Code
<b>Guardian</b>	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 \_\_\_\_\_

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.**

**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.

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Parent/ Legal Guardian (Print)

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Signature (parent/legal guardian)

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Relationship to patient

---

Date

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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: