**Welcome to Southtowns Pediatrics!**

Patient Registration

Patient Information

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please Circle Born: Male or Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household Information

Mom’s First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mom’s Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mom’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mom’s Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dad’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dad’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pt’s Billing Address: [ ] Same as above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Welcome to our Practice!**

Patient Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

Please take the time to complete these forms as accurately as possible to ensure quality of care. Please circle the correct answer(s) and fill out to complete form to the best of your ability.

We are required to ask the following demographic information below. Please complete to the best of your knowledge/if applicable to you. If you leave blank we will designate it as “Declined to answer/specify”

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Identity: \_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_

PEDIATRIC PATIENT HISTORY FORM

BIRTH HISTORY

Please List Place of Birth (Hospital Name) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery: Vaginal Cesarean - due to: \_\_\_\_\_\_\_\_\_\_\_

Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child was born after \_\_\_\_\_\_\_\_\_\_\_\_ weeks of pregnancy.

Did this child have any unusual problems in the hospital? Yes No If yes, please indicate problems:

Trouble breathing, Blue spells, Yellow Jaundice, Trouble Feeding,

Other, please list? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Continue to Next Page……………..

MEDICAL HISTORY

Hospitalizations (Overnight only, NOT ER)? Yes None If yes, please list date of hospitalization and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries (including circumcision)? Yes None If yes, please list surgery and date:\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious Injuries (fractures, concussions, etc)? Yes None If yes, please indicate Description of injury and date of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies? Yes None If yes, please list Medication **WITH** Type of Reaction: \_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Chronic Illnesses or medical issues we should be aware of? None Yes If yes, please list Chronic conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child seen a specialist? Yes No If yes, please list specialist name and date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you seen a Dentist within the past year? Yes No If yes, indicate name of dentist and last visit date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have specific communication requirements due to hearing, vision or cognition issues?

Yes No

If yes, Please Circle any that Apply: Glasses Contacts Hearing Aid

Intellectual Disability Sensory Impairment Other

If other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Continue to Next Page……………..

SOCIAL HISTORY

Please circle the appropriate answer(s)

Parents: Married Divorced Separated Widowed Single

Please list all persons whom live in your home/relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently enrolled in school or daycare? Yes No NA

If yes, where are they enrolled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, does your child feel safe in the daycare or school? Yes No

Does your child have difficulty interacting in everyday social tasks? Yes No

Does your child have difficulty maintaining an adequate social life? Yes No

If yes to either, do you want/need resources regarding this issue: Yes No

Any special communication needs? Yes No

Does your child participate in regular exercise? Yes No If yes, please list type and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child drink caffeine? Yes No If yes, What type/how much/day?\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child smoke? Yes No If yes, how many cigarettes/day? \_\_\_\_\_\_\_\_\_\_\_

PATIENT SAFETY

Does the patient feel safe at home? Yes No If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient exposed to secondhand smoke? Yes No Any smokers at home? Yes No

Are there carbon monoxide and smoke detectors at home? Yes No

Please Continue to Next Page……………..

ASSISTANCE/NEEDS

Do you have resources available to meet your daily needs? Yes No

If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language if other than English for Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CULTURE/RELIGION

Is there anything we need to know about your religion or culture in order to care for your child?

Yes No

If YES, please explain in detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please Continue to Next Page…………….

Patient Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

FAMILY MEDICAL HISTORY

Please fill out blank or place a check mark in the boxes that apply to patient’s family medical history. PLEASE BE AS SPECIFIC AS POSSIBLE

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Child’s Mother** | **Child’s Father** | **Sibling(s)**  **Write Sibling Name/gender** | **Child’s Grandmother**  **On Mom’s side** | **Child’s Grandfather**  **On Mom’s side** | **Child’s Grandmother**  **On Dad’s side** | **Child’s Grandfather**  **On Dad’s side** |
| Indicate Alive or Deceased (If Deceased, list Cause of Death **AND** year) |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Diabetes (Indicate: Adult (2) or Child onset (1)) |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Smoker |  |  |  |  |  |  |  |
| Crohn’s/UC |  |  |  |  |  |  |  |
| Cystic Fibrosis |  |  |  |  |  |  |  |
| Alcohol Abuse/Addiction |  |  |  |  |  |  |  |
| Drug Abuse/Addiction |  |  |  |  |  |  |  |
| Mental/Psychiatric Illness |  |  |  |  |  |  |  |
| Eating Disorder |  |  |  |  |  |  |  |
| Social Problems |  |  |  |  |  |  |  |
| Hypothyroidism |  |  |  |  |  |  |  |
| Migraines |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |
| Cancer (Please indicate type) |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |

Please Continue to Next Page…………….

**John Mulawka DO P.C.**

**Big Tree, Derby, Silver Creek, Dunkirk and Abbott Road Pediatrics**

**www.southtownspediatrics.com**

Disclosure Authorization

Please check contact preferences for appointment information (select all that apply):

Home Phone \_\_\_\_ Work Phone \_\_\_\_

Mobile Phone \_\_\_\_ Mobile Text \_\_\_\_

Mail \_\_\_\_ E-Mail/Portal \_\_\_\_

Please check contact preferences for medical information (select all that apply):

Home Phone \_\_\_\_ Work Phone \_\_\_\_

Mobile Phone \_\_\_\_ Mobile Text \_\_\_\_

Mail \_\_\_\_ E-Mail/Portal \_\_\_\_

* I give permission to leave voicemail messages on my phone, including information about test result availability for my child, follow up requirements, health inquires, and test results.
* I give permission to fax or otherwise send my child’s medical records to me including test results, x-ray reports and/or encounter notes. I understand that some methods of delivery may not be secure and could affect the privacy of my child’s personal health information.
* I give permission to fax or otherwise communicate with my child’s school including providing my child’s personal health information to the school for attendance related questions and to authorize or limit my child’s participation in school activities including sports.

I hereby authorize the release of my child’s protected health information to the following people (**please include Mother and Father if applicable**):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to contact regarding appointments: Yes \_\_\_\_ No \_\_\_\_

Permission to disclose medical information: Yes \_\_\_\_ No \_\_\_\_

Permission to seek medical treatment for patient in my absence (including consent for an x-ray, diagnostic testing, minor laceration repairs, and medications and other treatments that the professionals at John Mulawka DO PC may deem necessary for treatment. I also authorize them to sign any required documents on my behalf for patient registration and billing. Yes \_\_\_\_ No \_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to contact regarding appointments: Yes \_\_\_\_ No \_\_\_\_

Permission to disclose medical information: Yes \_\_\_\_ No \_\_\_\_

Permission to seek medical treatment for patient in my absence (including consent for an x-ray, diagnostic testing, minor laceration repairs, and medications and other treatments that the professionals at John Mulawka DO PC may deem necessary for treatment. I also authorize them to sign any required documents on my behalf for patient registration and billing. Yes \_\_\_\_ No \_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to contact regarding appointments: Yes \_\_\_\_ No \_\_\_\_

Permission to disclose medical information: Yes \_\_\_\_ No \_\_\_\_

Permission to seek medical treatment for patient in my absence (including consent for an x-ray, diagnostic testing, minor laceration repairs, and medications and other treatments that the professionals at John Mulawka DO PC may deem necessary for treatment. I also authorize them to sign any required documents on my behalf for patient registration and billing. Yes \_\_\_\_ No \_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 I have a certain right to privacy regarding my child’s protected health information. I understand that this information can be used for:

* The purpose of diagnosing or providing treatment for my child
* Obtaining payment for my child’s health care bills including third party payers
* Conducting health care operations for Big Tree, Derby, Silver Creek, and Dunkirk Pediatrics

The Pediatric Practices Notice of Privacy Practices has been provided to me. I understand that I have the right to review this notice prior to signing this document. The Notice of Privacy Practices describes the types, uses, and disclosures of my child’s protected health information that will occur in the treatment, payment of bills, or performance of health care operation at our practice. The Notice of Privacy Practices also describes my rights and this pediatric office’s duties with respect to my child’s protected health information.

We reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a REVISED COPY of the Notice of Privacy Practices by calling the office and requesting a copy be sent by mail. I have the right to revoke this consent, in writing, anytime.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Southtowns Pediatrics

Address/Phone/Fax:

Medical Records Release

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, or my authorized representative, hereby authorize and request the disclosure of all protected medical information by either mail or fax to Dr. John Mulawka DO PC at Big Tree Pediatrics for the purpose of review and evaluation in connection with my medical care to be sent from:

Name and Address of Previous Doctor:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In accordance with the NYS Law and the Privacy Rule of the HIPAA of 1996, I understand that I have the right to revoke this authorization at any time by writing to the health care provider that I have listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. I understand that my treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditional upon my authorization of this disclosure. I understand that the information disclosed under this authorization might be redisclosed by the recipient and that this re-disclosure may no longer be protected by federal or state law.

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_