Welcome to our practice!

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

Soc. Sec. # _____

School _____ Grade _____

Child's home address _____

_____

City, State, Zip _____

Phone: _____

Primary Language Spoken: _____

☐ Mother ☐ Grandmother ☐ Guardian

Name _____

Home Phone _____

Work Phone _____

Employer _____

Occupation _____

Soc. Sec. # _____

DL # _____

Parent's Marital Status

— Single — Married

— Divorced — Widowed

— Separated

Primary Insurance

Insurance Company _____

Group # _____

Employee # _____

Ins. Co.'s Address _____

_____

City, State, Zip _____

Deductible _____ Copay _____

Insured Party

Name _____

Relationship _____

Address _____

City, State, Zip _____

Soc. Sec. # _____

DL # _____

DOB _____

Employer _____

Occupation _____

☐ Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____

Work Phone _____

Soc. Sec. # _____

DL # _____

Employer _____

Who is responsible For Making Appointments?

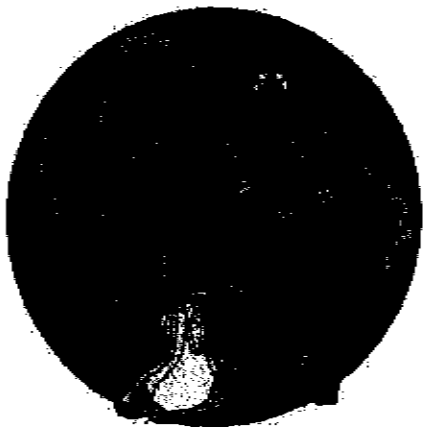
Name _____

Home Phone _____

Work Phone _____ Ext. _____

Best time to call:

Time: _____ Days _____



Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the method which you prefer the best. Payment in full at each visit.

_____Cash _____Personal Check

_____ Credit Card _____ Visa _____ MC

_____ I wish to discuss the office's payment policy.

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in us being unable to provide additional services except for emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent if minor

HEALTH HISTORY

Patient's Name _____ Date of Birth _____

Pregnancy & Birth

Mother's age at pregnancy _____
Any medications taken during pregnancy? Y N _____
(Excluding vitamins)
Any illness during pregnancy? Y N _____
Any smoking-alcohol-drugs during pregnancy? Y N _____
Was baby . . . Early – Late – On time? Type of delivery _____
Birth Weight _____ Length _____
Complications? Y N _____
Problems with baby at birth with: Breathing? Y N Jaundice? Y N
Other _____
Any problems soon after? At home or nursery? _____

Past Medical History

Allergic reactions to: Medicine? Y N Food? Y N Animals? Y N
Insect bites? Y N Other: _____
Any medications taken on a regular basis? Y N _____
_____
Immunizations - up to date? Y N Do you have a record? Y N
Any hospitalizations? (When . . . Where . . . Why?) _____
_____
Any serious injuries? Y N _____
Any . . . (check any that apply)

__ chicken pox	__ asthma / wheezing	__ whooping cough
__ eczema / hives	__ urinary infections	__ red measles
__ Rheumatic fever	__ anemia	__ seizures
__ joint problems	__ bleeding tendency	__ blood transfusions
__ hepatitis	__ ear infections	__ Scarlet fever

problems with __ hearing /__ vision Other: _____

Feeding & Nutrition

Appetite usually good? Y N Colic / Feeding problems? Y N
Breast Fed? Y N Number of Months _____
Formula? Y N Brand / Type _____
Vitamins? Y N Brand _____

Development & Behavior

Age @ which child: sat alone _____ Walked _____ Used sentences _____
Toilet trained _____ Learned to ride a bicycle _____
Any learning problems? Y N _____
Getting along well with other children? Y N
Behavior Problems? Y N _____
Bad Habits? Y N _____

Family Profile

Parents – Married? ____ Single? ____ Divorced? ____
Father's age _____ Highest School grade ____ Health? _____
Mother's age _____ Highest School grade ____ Health? _____
Any Siblings? (Name & Age) _____

Family Medical History Use the following abbreviations: F - father, M - mother, B - brother, S - sister, MF - mother's father, MM - mother's mother, FM - father's mother, FF - father's father, A - aunt, U - uncle, C - cousin.

Asthma / allergies _____	Epilepsy / seizures _____
Migraine _____	Diabetes _____
High Blood Pressure _____	Cholesterol Probs _____
Heart disease _____	Stroke _____
Drug / alcohol probs _____	Anemia _____
Cancer _____	Arthritis _____
AIDS _____	SIDS _____
Deafness _____	Tuberculosis _____
Cystic fibrosis _____	Musc. Dystrophy _____
Mental retardation _____	Birth defects _____

Consent for Purposes of Treatment, Payment and Health Care Operations

I, _____, consent to the use or disclosure of my child's protected health information by **Harbour Island Pediatrics** for the purpose of diagnosing and providing treatment to my child, obtaining payment for my health care bills or to conduct health care operations of **Harbour Island Pediatrics.**

I understand that diagnosis or treatment of my child by **Harbour Island Pediatrics** may be conditioned upon my consent evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how his/her protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Harbour Island Pediatrics** is not required to agree to the restrictions that I may request. However, if **Harbour Island Pediatrics** agrees to a restriction that I request, the restriction is binding on **Harbour Island Pediatrics.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Harbour Island Pediatrics** have taken action in reliance on this consent.

My child's "protected health information" means health information, including his/her demographic information, collected from me and created or received by his/her physician, another health care provider, a health plan, a health care clearinghouse. This protected health information relates to his/her past, present, or future physical or mental health or condition and identifies him/her, or there is a reasonable basis to believe the information may identify my child.

I understand I have the right to review **Harbour Island Pediatrics'** Notice of Privacy Practice prior to signing this document.

The **Harbour Island Pediatrics** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of his/her protected health information that will occur in his/her treatment, payment of his/her bills or in the performance of healthcare operations of the **Harbour Island Pediatrics.**

The Notice of Privacy Practices for **Harbour Island Pediatrics** is also provided at 1301 PLANTATION ISLAND DR SOUTH, SUITE 106B, St. Augustine, Florida 32080.

This Notice of Privacy Practices also describes my rights and the duties of **Harbour Island Pediatrics** with respect to my child's protected health information.

Harbour Island Pediatrics reserves the right to change the privacy practices that are described in the notice of privacy practices.

I may obtain a revised notice of privacy practices by calling the office and requesting the revised copy be sent in the mail or asking for one at the time of my next appointment.

Print name of patient: _____

Personal representative: _____

Signature: _____

Date: _____

MEDICAL INFORMATION RELEASE

I, _____, being the parent and/or legal guardian of a

minor child named _____, born _____
do hereby authorize the release of any or all medical information pertaining to my child to the below named individuals over the age of 18 years of age. I understand that if someone not listed below requests medical information for my child it will not be given. This authorization may be withdrawn by the parent / guardian at any time by written notice.

Name	Relationship to the Patient
1.	
2.	
3.	
4.	

Parent / guardian **Date**

Witness **Date**

POS® Reorder # 1104813

Harbour Island Pediatrics

Effective immediately, our office must be given notice that you intend to cancel your appointment at least 24 hours in advance. Failure to give notice of cancellation will result in a cancellation charge of $25.00.

Thank you for your understanding and consideration.

Signature _____ **date** _____

Please print patient's name

_____

POS® Reorder # 1034595

Harbour Island Pediatrics
1301 Plantation Island Dr. S., Suite 106B
St. Augustine, FL 32080
Phone (904) 461-8906
Fax (904) 461-8907

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Previous Doctor _____

Address: _____

_____

Phone # _____ Fax # _____

INFORMATION BELOW WILL BE DISCLOSED TO: *HOMERO SICANGCO, JR., M.D.*

INFORMATION TO BE USED OR DISCLOSED:

Information covered by this authorization includes: ALL RECORDS (INCLUDING DRUG/ALCOHOL/MENTAL HEALTH/HIV INFORMATION.)

EXPIRATION DATE OF AUTHORIZATION

This authorization is effective through ____ /____ /____ unless revoked or terminated earlier by the patient or the patient's personal representative.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation.

RIGHTS OF THE INDIVIDUAL

You may inspect or request a copy of information used or disclosed under this authorization.
You may refuse to sign this authorization.

_____

Name of Patient Date of Birth

_____

Signature of Patient Representative (required if patient is a minor) Date

_____

Relationship of Patient Representative to Patient

HARBOUR ISLAND PEDIATRICS

PATIENT: _____ **DOB:** _____

PATIENT RECEIPT OF HIPAA PRIVACY NOTICE

Upon receipt of this Notice of Privacy Practices, please sign the **Acknowledgement of Receipt Notice** and return it to the following address.

1301 Plantation Island Dr., Suite 106B
St. Augustine, FL 32080

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receipt of the *Notice of Privacy Practices* of Harbour Island Pediatrics.

- By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Harbour Island Pediatrics.

Our Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice. If you have any questions about our *Notice of Privacy Practices*, please contact our office staff at (904) 461-8906.

Signature: _____ Date: _____

If other than the patient, specify relationship: _____

Signature: _____ Date: _____

If other than the patient, specify relationship: _____

Signature: _____ Date: _____

If other than the patient, specify relationship: _____

Signature: _____ Date: _____

If other than the patient, specify relationship: _____

Signature: _____ Date: _____

If other than the patient, specify relationship: _____

FOR Doctor's USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

If the Doctor's Office is not able to obtain the patient's acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:

Effort to obtain acknowledgement:

___ in-person request (send copy of letter inclusion in patient's record)

Reason acknowledgement was not obtained:

___ Patient refused to sign

___ Patient did not return acknowledgement via mail, e-mail

___ Patient unable to sign

Staff: Signature / Print Name / Date _____