TREASURE COAST PEDIATRICS
HEALTHY KIDS, HAPPY PARENTS

3745 11th Circle – Suite 108 ● Vero Beach, FL 32960
Ph (772) 567-1552 ● Fax (772) 567-5269

PATIENT INFORMATION			
Patient's Full Name (Last, First):			Nickname/Preferred Name:
Date of Birth:	Sex: □ Male □ Female □ Other: _____ □ Declined to specify		Social Security #:
Race: □ White □ Black/African American □ American Indian/Alaska Native □ Asian □ Native Hawaiian/Pacific Islander □ Other: _____ □ Declined to specify			
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Declined to specify			
Preferred Language: □ English □ Spanish □ Other: _____			
Street Address:			
City:		State:	Zip Code:
Home Phone #:	Cell Phone #:		Work Phone #:
Siblings (Names and Birthdates): #1: _____ #2: _____ #3: _____			

PHARMACY		
Pharmacy Name:	Address:	Phone #:

MOTHER/LEGAL GUARDIAN	FATHER/LEGAL GUARDIAN
Name:	Name:
Relationship: □ Biological □ Adoptive □ Guardian □ Foster □ Step-Mom	Relationship: □ Biological □ Adoptive □ Guardian □ Foster □ Step-Dad
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
E-mail Address:	E-mail Address:
Mailing Address: □ Same as Patient	Mailing Address: □ Same as Patient
Home Phone #:	Home Phone #:
Cell Phone #:	Cell Phone #:
Work Phone #:	Work Phone #:
Employer:	Employer:
Occupation:	Occupation:

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EMERGENCY CONTACT	
Name:	Relationship:
Address:	Phone #:

PRIMARY INSURANCE INFORMATION		
Insurance Company:		Policy #:
Policy Holder's Name:	DOB:	S.S. #:
SECONDARY INSURANCE INFORMATION		
Insurance Company:		Policy #:
Policy Holder's Name:	DOB:	S.S. #:

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AUTHORIZATION TO TREAT/HIPAA RELEASE OF INFORMATION

I, _____ phone # _____parent/legal guardian of:

_____authorize Treasure Coast Pediatrics to provide medical treatment to said child. I authorize the following adult(s), acting as my agent to accompany and consent for treatment, testing, and immunizations for my child.

I authorize Treasure Coast Pediatrics to release medical information regarding my child to the following person(s):

***I understand that this person may be required present proper ID when bringing my child for Treatment.**

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

□ **I authorize Treasure Coast Pediatrics to leave a voicemail:**

_____ DATE ___/___/___
Parent/Guardian signature

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have been received a copy of the Provider Notice of Privacy Practices for Treasure Coast Pediatrics/. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the duties of Treasure Coast Pediatrics with respect to my protected health information.

Patient Name_____ DOB: ___/___/___

Parent/Guardian Signature_____ Date: ___/___/___

Witness Signature_____ Date: ___/___/___

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MEDICAL HISTORY

Child's Name: _____ Date of Birth: _____

Person Completing Form: _____ Relationship: _____

CURRENT MEDICATIONS:

Medication Name		Dose	How many times a day?

CHILD'S MEDICAL HISTORY: *(please mark all that apply)*

- □ ADD/ADHD
- □ Allergies
- □ Anemia
- □ Asthma
- □ Bleeding/clotting disorder
- □ Heart Murmur
- □ Congenital Heart Disease
- □ High Blood pressure
- □ Kidney Disease
- □ Liver Disease
- □ Hepatitis
- □ Chicken Pox
- □ Seizures
- □ Disability
- □ Headaches
- □ Hearing Problems
- □ Vision Problems
- □ Recurrent ear infections
- □ Dental Decay
- □ Eczema
- □ Vesicoureteral reflux
- □ Other:

HOSPITALIZATIONS AND SURGICAL HISTORY:

Hospitalization/Surgery/Procedure:	Year:

FAMILY HISTORY:

Please indicate if there is a family history of any of the following:

Medical Condition	Family Member		Medical Condition	Family Member
ADD/ADHD			Hearing Disability	
Alcohol/Drug Abuse			High Cholesterol	
Allergies			High Blood Pressure	
Asthma			HIV/AIDS	
Birth Defects			Learning Disability	
Blood Disorder			Mental Illness	
Cancer	*(please include what type)*		Migraines	
Heart Disease			Scoliosis	
Seizure Disorders			Speech Problems	
Developmental Delay			TB/Lung Disease	
Diabetes			Stroke	
Genetic Disorder			Thyroid Disease	
Hepatitis/Liver Disease			Other:	

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MEDICAL RECORDS RELEASE AUTHORIZATION

NO DISK RECORDS PLEASE

I, _____ (PRINT PARENT/GUARDIAN NAME), authorize the release of medical records of
_____ (PRINT NAME OF PATIENT), _____ (PATIENT'S DOB)

□ Obtaining Records From: **OR** □ Releasing Records To:

_____
Recipient Name Street Address City, State, ZIP code

_____
Phone Number Fax Number

INFORMATION TO RELEASE (CHECK ALL THAT APPLY):

□ Last 2 years of Medical Records	□ Immunization	□ Laboratory Reports
□ Imaging	□ Consultation Documentation	□ Hospital Records
□ Prescription Data	□ Other (Specify): _____	

If my record contains the following, it will be released if box is checked:

□ Substance Abuse □ Mental Health □ HIV/STD Testing/Treatment □ Pregnancy Testing

PURPOSE OF DISCLOSURE:

□Transfer of Care □ Continuing Care □ Personal Copy □ Other_____

This authorization is valid for 1 (one) year from date of signature unless otherwise specified. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released. I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

NOTICE: There may be costs associated with this request in compliance with State and Federal laws.