** PATIENT INFORMATION FORM**

**Patient:** revised Feb 2023

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: | First Name: | MI | Gender:  | Date of Birth: |

|  |  |  |  |
| --- | --- | --- | --- |
| Address: | City: | State: | Zip: |

**Mother/Father/Guardian (Circle One)**

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: | First Name: | Date of Birth: | SS# |

|  |  |  |  |
| --- | --- | --- | --- |
| Address: | City: | State: | Zip: |
| Employer: | Occupation: | Home Phone: | Cell Phone: |

**Mother/Father/Guardian (Circle One)**

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: | First Name: | Date of Birth: | SS# |

|  |  |  |  |
| --- | --- | --- | --- |
| Address: | City: | State: | Zip: |
| Employer: | Occupation: | Home Phone: | Cell Phone: |

|  |
| --- |
|  |
| Sibling: | Gender: | Date of Birth: |
| Sibling: | Gender: | Date of Birth: |
| Sibling: | Gender: | Date of Birth: |
| Sibling: | Gender: | Date of Birth: |
| Children Live With: □ Mother □ Father □ Guardian: |

**INSURANCE INFORMATION:**

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| --- | --- | --- |
| Insurance Carrier: | Policy ID: | Co-payment $ |
| Name of Insured: | Date of Birth: | Relation: |

|  |
| --- |
| Party Responsible for Payment of Medical Services: □ Mother □ Father □ Guardian: |

**PHARMACY INFORMATION:**

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| --- | --- | --- |
| Local Pharmacy: | Address: | Phone: |
| Mail Away Pharmacy: | Address: | Phone: |

Signature of Parent/Guardian/Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Parent/Guardian/Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA AUTHORIZATION STATEMENT:**

and

**AUTHORIZATION TO ACCOMPANY MINOR:**

Medical care or immunizations cannot be provided to a minor that is not accompanied by their parent or legal guardian unless permission is granted to another specified adult (over the age of 18). Please list the family members or other persons who may accompany your child so we can discuss your child's general medical condition and diagnoses (including treatment, health care operations and payment). Please be made aware that any personal health information relating to the minor pertinent to the visit may be disclosed.

**I (we) hereby authorize:**

|  |  |  |
| --- | --- | --- |
| Name: | Phone: | Relation: |
| Name: | Phone: | Relation: |
| Name: | Phone: | Relation: |
| Name: | Phone: | Relation: |

to accompany my/our child to the office of Decernia Uy M.D. PC in my absence. I (we) authorize Decerina Uy M.D and her personnel to deliver medical services to my child.

* **Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.**

|  |  |  |  |
| --- | --- | --- | --- |
| Address: | City: | State: | Zip: |

* **Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.**

***Please be aware that a cell phone is NOT a secure and private line.***

|  |
| --- |
| Telephone Number: |

* Please indicate if confidential messages (i.e., appointment reminders) can be left on your telephone answering machine or voicemail. □ Yes □ No

**Signature of Parent/Guardian/Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name of Parent/Guardian/Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION of TREATMENT, ASSIGNMENT of BENEFIT and CONSENT TO TREAT MINOR**

I authorize Decerina Uy MD PC FAAP and her personnel to treat my child. Being the parent /legal guardian of the above minor, I consent to the said procedures being performed whether I am present or not and this, my signature hereunder, shall be full and sufficient authority. Should the need arise to perform services not set out above, Decerina Uy MD aka Decerina Uy Pediatrics may obtain consent by telephone or by letter/fax granting such consent.

I hereby request and consent to diagnostic procedures, medical treatments, and immunizations deemed advisable by the

professional staff of Decerina Uy Pediatrics. I acknowledge that I have read this consent form and understand its contents. I have had the opportunity to discuss it, and any questions have been answered to my complete satisfaction.

I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment made directly to Decerina Uy MD for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. I hereby authorize said assignee to release all information necessary to secure payment.

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian/Patient's signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_