Joseph T. Sherrel, M.D., FAAP
Pediatric and Adolescent Medicine

Patient Name:_____Sex_____DOB_____

Mailing Address_____Email_____

City_____State_____Zip_____

Home #_____Cell#_____

SSN#_____Best Phone #_____

Fathers Name_____DOB_____

Employer_____Work #_____

Mothers Name_____DOB_____

Employer_____Work #_____

Siblings Name_____

Name of Insurance_____Pharmacy_____

Name of Carrier_____DOB_____

Referred By_____

Previous Physician:_____

Name and Phone # of nearest relative not living with you_____

Ethnicity:circle Non-Hispanic Hispanic

Race:_____Nationality_____(ex. American)

Do you give consent for us to receive patient's medication history from all pharmacies? Circle Yes No
Do you give consent for us to list patient in the state immunization registery to keep track of your child's shots? Y N
Do you give consent for us to adminsiter all appropiate and required immunizations: Circle Yes No
Birth History: Circle Full Term Premature
Past Medical History: Hospitalizations_____Surgeries_____
Chronic Medical Problems_____
DRUG ALLERGIES_____

Patient Disclosure Form for Health Care Information

North Florida Pediatrics

The Health Insurance Policy & Accountability Act of 1996 (S160.103)

Defines individual health information as information, including demographic information collection from an individual and:
1. Created or received by a health care provider, health plan, employer or healthcare clearing house and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual.
3. The information therefore identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

Permitted disclosure (S164.502) and uses be a health care provider include:

1. For treatment, payment or health care operations as permitted under law
2. Uses or disclosure to personal representative assigned by the patient
3. Disclosure to the parents or persons acting in loco parentis to an emancipated minor
4. For case management or care coordination for the individual or to direct or recommend alternative treatments, therapies, health care providers, health care settings.

Patients name_____ **DOB**_____ **SSN**_____

My child is a patient of North Florida Pediatrics health care facility. I understand that I am required to inform the facility of persons to whom they may disclose medical information. These assigned person by be changed at any time. This disclosure is effective April 14, 2003 and will continue until changed by me. This facility has provided me with a list of all person and agencies, or payers to whom my medical information may be disclosed during the course of any medical treatment by the facility. I HAVE READ THE PERMITTED DISCLOSURE FORM AND ASSIGN THE FOLLOWING TRUSTIES: (Family members, lawyer, other who can access medical information.)

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship_____

Signature:_____ **Date**_____