__ ANNUAL ___/___/_____
__ NO CHANGE_____
__CHANGE OF ADDRESS
__CHANGE OF INSURANCE
__NEW PATIENT

JACALYN BLACKWELL-WHITE, M.D. P.A.

DATE:_____

PATIENT INFORMATION

PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS

CHILD'S NAME:_____ **NICK NAME:**_____

LAST *FIRST* *MI*

DATE OF BIRTH:_____ **MALE**___ **FEMALE**___ **PATIENT'S SSN:**_____

PRIMARY LANGUAGE:_____**INTERPRETER NEEDED:**_____**SPECIAL COMMUNICATION NEEDS:**_____

ETHNICITY: HISPANIC__NOT HISPANIC__UNKNOWN__ **RACE:** AMERICAN INDIAN__ASIAN__BLACK__HAWAIIAN__WHITE__OTHER__

NAME OF PHARMACY:_____**PHONE:**_____**ADDRESS:**_____

PATIENT LIVES WITH:_____**SIBLING(S) NAME(S) AT THIS OFFICE**_____

_____

PARENT\GUARDIAN INFORMATION

PARENT\GUARDIAN 1:_____ **RELATIONSHIP**_____

LAST *FIRST* *MI*

LIVES WITH PATIENT: Y / N **SSN:**_____ **DATE OF BIRTH:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP**_____

HOME PHONE:_____ **CELL:**_____**EMAIL:**_____

EMPLOYER:_____ **EMPLOYER PHONE:**_____

PREFERRED MEANS OF CONTACT FOR: ***MEDICAL ISSUES*** - HOME__CELL__EMAIL__ ***APPOINTMENT REMINDERS*** – HOME__CELL__EMAIL__

PARENT\GUARDIAN 2:_____ **RELATIONSHIP**_____

LAST *FIRST* *MI*

LIVES WITH PATIENT: Y / N **SSN:**_____ **DATE OF BIRTH:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP**_____

HOME PHONE:_____ **CELL:**_____**EMAIL:**_____

EMPLOYER:_____ **EMPLOYER PHONE:**_____

PREFERRED MEANS OF CONTACT FOR: ***MEDICAL ISSUES*** - HOME__CELL__EMAIL__ ***APPOINTMENT REMINDERS*** – HOME__CELL__EMAIL__

IF PARENTS ARE ESTRANGED, DIVORCED OR SEPARATED, PLEASE COMPLETE:

WHO HAS CUSTODY?_____ **ARE THERE ANY LEGAL RESTRICTIONS PREVENTING NON-CUSTODIAL PARENT FROM CONSENTING TO MEDICAL TREATMENT FOR THE PATIENT OR OBTAINING INFORMATION ABOUT THE CHILD'S MEDICAL TREATMENT?** YES___ NO___ **IF YES PLEASE EXPLAIN AND PROVIDE A COPY OF ANY LEGAL PAPERWORK THAT SUPPORTS THIS RESTRICTION.**_____

EMERGENCY CONTACT OTHER THAN PARENTS: _____**PHONE:**_____

RELATIONSHIP:_____

HEALTH INSURANCE - PRIMARY POLICY

POLICY HOLDER'S NAME_____ **DATE OF BIRTH**_____**RELATIONSHIP:**_____

INSURANCE CARRIER:_____ **ID #**_____**GROUP #**_____

HEALTH INSURANCE - SECONDARY POLICY

POLICY HOLDER'S NAME_____ **DATE OF BIRTH**_____**RELATIONSHIP:**_____

INSURANCE CARRIER:_____ **ID #**_____**GROUP #**_____

I hereby authorize direct payment of medical\surgical benefits to Windsor Pediatrics, for the services rendered by him\her in person or under his\her supervision. I understand that I am financially responsible for any Deductibles, Co-pays, Non-covered service, Coinsurance and any or all balances not covered by my insurance. I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as is the original.

PARENT\GUARDIAN\PATIENT SIGNATURE:_____
DATE:_____

AUTHORIZATION OF MEDICAL CARE

I authorize the following people to bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence. This does not allow them to have access to confidential health information that is not relevant for the visit. I also understand that telephone triage and advice services will be extended to the above persons only if such are regarding direct patient care while the child is in their care. In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If we cannot reach you, we will not refuse treatment. This serves as consent for medical treatment we deem as medically necessary and appropriate.

*** Please circle yes or no to give them additional specific authorizations. Any other documents to be picked up by non-legal guardians must have written consent.*

NAME:_____ **RELATIONSHIP:**_____
***** Y \ N MAY PICK UP PRESCRIPTIONS Y \ N MAY PICK UP SHOT RECORDS***

NAME:_____**RELATIONSHIP:**_____
***** Y \ N MAY PICK UP PRESCRIPTIONS Y \ N MAY PICK UP SHOT RECORDS***

PARENT\GUARDIAN\PATIENT SIGNATURE:_____
DATE:_____

NOTICE OF PRIVACY PRACTICES

I have been given an opportunity to read the practice's HIPPA Notice of Privacy Practices and I am entitled to a personal copy if I ask for one.

PARENT\GUARDIAN\PATIENT SIGNATURE:_____
DATE:_____