Professional Park Pediatrics: Patient Demographics

Patient Last Name: _____ Patient First Name: _____

Date of Birth: _____/_____/_____ Preferred Name: _____ Gender at Birth (Circle): M F

Address: _____

Primary Language: _____ Preferred Pharmacy: _____

Race: _____ ***Ethnicity (Circle):*** Hispanic or Latino - Not Hispanic or Latino - Decline to Respond

□ Mom □ Dad □ Legal Guardian	□ Mom □ Dad □ Legal Guardian
Name: _____	Name: _____
DOB: _____/_____/_____ Phone #: _____	DOB: _____/_____/_____ Phone #: _____

Who is the primary caregiver? □ Mom □ Dad □ Both □ Other _____

Please List All Children's Names & Birth Dates

_____

_____

_____

_____

New Patient Consent to the Use and Disclosure of Health Information

I understand that as part of my child's health care, Professional Park Pediatrics originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment,
- A means of communication among the many healthcare professionals who contribute to my child's care,
- A source of information for applying my diagnosis and surgical information to my child's bill,
- A means by which a third-party payer can verify that services billed were provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I further understand that Professional Park Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Professional Park Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided.

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax (to other physicians ONLY).

_____ _____

Signature **Date**