Capote Pediatrics

PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ MI: __ Last Name: _____

Birth Date: _____/_____/_____ Gender Assigned at Birth: Male ☐ Female ☐

PARENT/GUARDIAN INFORMATION:

Email Address: _____ Pharmacy: _____

Mailing Address:_____

Address Line 2: _____ City: _____ State: ___ Zip:_____

First Name: _____ **Last Name:** _____

Relation: _____ Phone: (____)_____

Alt. Phone: (____)_____ Occupation: _____

First Name: _____ **Last Name:** _____

Relation: _____ Phone: (____)_____

Alt. Phone: (____)_____ Occupation: _____

PERMISSION TO CONTACT:

Leave a detailed message on your answering machine at home? Yes ☐ No ☐

Leave a detailed message at your place of employment? Yes ☐ No ☐

EMERGENCY CONTACT:

This does not give consent for your child's medical records, only to contact in an emergency.

First Name: _____ Last Name: _____

Relation: _____ Phone: (____)_____

INSURANCE (If applicable):

Name of Insurance: _____ ID #: _____

Policy Holder: _____

Policy Holder DOB:_____/_____/_____

NOTICE OF RESPONSIBILITY

I understand Capote Pediatrics will file insurance claims on my behalf, however I am responsible for any charges on this account. ***Missed appointments and failure to cancel appointments before 24 hours of scheduled time will be assessed a $50 fee.*** Any unpaid balance 90 days overdue will be placed with a collection agency; the guarantor will be responsible for any collection fees.

_____

Parent/Guardian Signature Date

NOTICE OF PRIVACY ACT

With my consent, Capote Pediatrics may use and disclose protected health information (PHI) about my child to carry treatment, payment, and healthcare operations. I have the right to review the Notice of Privacy Practices prior to signing this consent. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Capote Pediatrics, 6995 Professional Pkwy E. Unit C, Sarasota, FL. 34240. With my consent Capote Pediatrics may mail to my home or other designated location, any items that may assist the practice in carrying out healthcare operations, such as appointment reminder cards and patient statements. By signing this form, I am consenting to Capote Pediatrics use and disclosure of my child's health information. Capote Pediatrics may decline to provide treatment to my child.

_____

Parent/Guardian Signature Date

Capote Pediatrics

LEAD RISK ASSESSMENT	Y	N
Child is suspected by a parent or a health-care provider to be at risk for lead exposure		
Child has a sibling or frequent playmate with elevated blood lead level		
Child is a recent immigrant, refugee, or foreign adoptee		
Child's parent or principal caregiver works professionally or recreationally with lead		
Child has a household member who uses traditional, folk, or ethnic remedies or cosmetics or who routinely eats food imported informally (e.g., by a family member) from abroad		
Child's family has been designated at increased risk for lead exposure by the health department because the family has local risk factors for lead exposure (e.g., residence in a designated high-risk zip code or near a known point source)		

TUBERCULOSIS RISK ASSESSMENT	Y	N
Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?		
In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?		
Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?		
Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?		
Have any members of the child’s household come to the United States from another country?		
Is the child exposed to a person who: □ Is currently in jail or who has been in jail in the past 5 years? □ Has HIV? □ Is homeless? □ Lives in a group home? □ Uses illegal drugs? □ Is a migrant farm worker?		
Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?		

VACCINATIONS	Y	N
Child is up to date on vaccines to the best of my knowledge		
Objections to vaccines required to enter schools		