YEARLY UPDATE
PATIENT INFORMATION

KINGS BAY PEDIATRICS

13101 S. Dixie Hwy., Suite 320
Miami, Florida 33156
(305) 253-5585

Today's Date: ______________

PATIENT'S NAME: ______________________________ M__ F__ Child's Birthday: __________
(First Name) (MI) (Last Name)

Parent's E.mail (Required) ______________________________

Address: ______________________________

City: ______________________ State: ________ Zip Code: ________

Home Telephone: (   ) ______________________________

Patient's Cell Phone: (18 years and older) (   ) ______________________________

PARENT NAME: ______________________ Parent D.O.B. ______________

Employer: ______________________ Work Phone: ______________

Home Telephone: (   ) ______________________ Mother's Cell Phone: ______________

Home Address (if different:) ______________________ Social Security # ______________

City: ______________________ State ________ Zip Code ________

PARENT NAME: ______________________ Parent D.O.B. ______________

Employer: ______________________ Work Phone: ______________

Home Phone: (   ) ______________________ Father's Cell Phone: ______________

Home Address (if different:) ______________________ Social Security # ______________

City: ______________________ State ________ Zip Code ________

PRIMARY LANGUAGE: ______________ **RELIGION OPTIONAL:** ______________

PRIMARY INSURANCE: ______________________________

PREFERRED PHARMACY & PHONE: ______________________________

Do you have other Children that come to our office. ☐ Yes ☐ No

	Last	First	D.O.B.
Name			
Name			
Name			
Name			

SIGNATURE REQUIRED ON REVERSE SIDE

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patient's' consent for uses and disclosures of health information about the patient to carry out treatment, payment or healthcare operations.

As our patient we want you to know that we respect the privacy of your personal medical records and we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing.

Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI)

If you choose to give consent in this document, at some future time you may request to refuse all ore part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

☐ Consent to post Photos / Holiday cards on office bulletin board.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payments of insurance benefits otherwise payable to me, but not exceed regular charges or the services provided, directly to **KINGS BAY PEDIATRICS** attending consulting physicians and other allied health professional deemed necessary by my physician(s) where **INSURANCE BENEFITS** are applicable. I certify that the information given by me in applying for payment under my insurance is correct and request that these payment of authorized benefits be made on my behalf.

GUARANTEE OF PAYMENT

For and in consideration of services rendered, I guarantee payments of any and all charges incurred which are not covered or allowable by my insurance.

I acknowledge that I have read and understand each of the provisions appearing on this page and by my signature consent and agree to such provisions individually and collectively.

____
Patient's Name

____
Guarantor/Parent's Signature

____
Today's Date

KINGS BAY PEDIATRICS **13101 S. Dixie Hwy., Suite 320** **MIAMI, FL 33156**

Patient's Name ______ Birth Date ______ Date First Seen ______

Race ______ Sex ______

Referred by ______

Parent Name ______ S.S. Number ______ D.O.B ______

Street Address ______

City ______ State ______ Zip Code ______ Phone ______

Employer ______ Occupation ______

Employer's Address ______ Work Place ______

Parent Name ______ S.S. Number ______ D.O.B. ______

Street Address (If Different) ______

City ______ State ______ Zip Code ______ Phone ______

Employer ______ Occupation ______

Employer's Address ______ Work Place ______

Medical Insurance Co. ______ ID # ______ Group # ______

Street Address ______

City ______ State ______ Zip Code ______ Phone ______

HOUSEHOLD/ FAMILY HISTORY

Biologic	Lives in Household	Shares in Parenting	NAME	AGE	HEALTH HISTORY
			Parent		
			Parent		
			Other		
		X	Sibling		
		X	Sibling		
		X	Sibling		

BIRTH HISTORY

Hospital ______ Birth WT. ______

OB ______ Blood Type Mother ______

☐ C/S ☐ SVD Blood Type Patient ______

☐ NICU

PAST HISTORY

Prior M.D. ______

Significant Illnesses ______

Hospitalization ______

Surgeries ______

Medications ______

Specialists ______

At Home

Caretakers ______

Primary Language ______

Pets ______

Smokers ______

Pool (Fenced) ______

Stairs (Gated) ______

Smoke Detectors ______

Lead Risk ______

County Water ______

Allergies ______

KINGS BAY PEDIATRICS

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305-253-5585

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: ____________________ **Date of Birth:** ____________________

Phone: H) ____________________ **Phone: W)** ____________________

Address: ____________________ **City/State/Zip:** ____________________

Please Note: There will be a fee for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ____________________ **Facility Phone:** ____________________

Facility Address: ____________________ **Facility Fax:** ____________________

City, ST, Zip: ____________________

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: ____________________
☐ Specific Information Requested:

____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral ____________________
☐ Other ____________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ____________________

Address: ____________________

City, State, Zip: ____________________ ☐ **Please mail records.**

Fax: ____________________ **Phone:** ____________________

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X ____________________ ____________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

____________________ ____________________

Printed name of Authorized Representative

Relationship / Capacity to patient

____

Address and telephone number of authorized representative

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Patients under 18 years of age

CONSENT FOR DISCUSSION WITH FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE
(Excludes CONFIDENTIAL Information)

Patient's Name: ______________________ **Birthdate**: ______________

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for my physician and his/her staff to verbally discuss my personal medical information with the following individual (s):

Name: ______________________ Relationship to Patient ______________
Phone # ______________________

Name: ______________________ Relationship to Patient ______________
Phone # ______________________

Name: ______________________ Relationship to Patient ______________
Phone # ______________________

Authorization:
Parent's Name: ______________ ______________________

Parent Signature (required): ______________________ Date: ______________