PATIENT REGISTRATION FORM

Patient Name: Last _____ First _____ MI _____ D.O.B _____

Social Security # _____ Sex: (M) (F) Patient lives with: Mother _____ Father _____ Other:_____

Please tell us, how well do you speak English? □ Very Well □ Well □ Not Well □ Not at All

Language: English, Spanish or Other: _____ Ethnicity: Hispanic or Non-Hispanic

Race: African American, Asian, Caucasian or Other: _____

Mother/Guardian: _____ D.O.B._____

Social Security # _____ Home Phone: _____

Address: _____City: _____ State: _____Zip Code:_____

Cellular Phone: _____ Work Phone: _____

Employer: _____ Email: _____

Father/Guardian: _____ D.O.B._____

Social Security # _____ Home Phone: _____

Address: _____City: _____ State: _____Zip Code:_____

Cellular Phone: _____ Work Phone: _____

Employer: _____ Email: _____

Primary Insurance: _____ Provider Phone: _____

Address for Claims: _____

Policy Holder: _____ SS#: _____ DOB: _____

Address (if different from above): _____

Relationship to Patient: _____ ID#: _____ Group#: _____

Secondary Insurance: _____ Provider Phone: _____

Address for Claims: _____

Policy Holder: _____ SS#: _____ DOB: _____

Address (if different from above): _____

Relationship to Patient: _____ ID#: _____ Group#: _____

Emergency Contact Person (other than parents): _____ Phone: _____

Referring Doctor: _____ Phone: _____

Primary Doctor/Pediatrician: _____ Phone:_____

Medical care cannot be given unless my child is accompanied by one of the following:

_____

Parent/Guardian signature _____ Relationship _____ Date _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize Pediatric Surgical Associates to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Surgical Associates for the medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, deductibles and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian signature _____ Relationship _____ Date _____

***** PLEASE FILL OUT THIS FORM COMPLETELY ******

What problem(s) is your child currently experiencing (what are we seeing your child for)?

_____

Check if patient has now or has had the following illness or problems:

_____Trauma (broken bones, loss of consciousness, etc)
_____ Stomach of intestinal problems
_____Growth problems
_____Seizures
_____Cancer
_____ Neurological problems
_____Anemia or blood disorder
_____Diabetes
_____Asthma
_____Heart problems
_____Emotional/behavioral problems
_____Past surgeries

Please explain: _____

_____

Please list any medications or supplements your child is currently taking: _____

_____

Are all immunizations up to date? _____

ALLERGIES (list or indicate none if applicable): _____

_____

FAMILY HISTORY

_____ Bleeding
_____ Cancer or blood disorder
_____ Problems with anesthesia
_____ Heart disease or liver disease

Please explain: _____

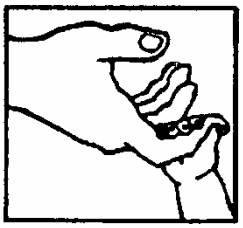
_____

BIRTH HISTORY

Type of delivery: _____ Vaginal _____ C-Section Baby Was: _____ Full Term _____ Premature Birth weight: _____
Was he/she on a ventilator? _____Yes _____ No If so, how long? _____
Other complications: _____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician (s) is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law that I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian signature _____ Relationship _____ Date _____



PEDIATRIC SURGICAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

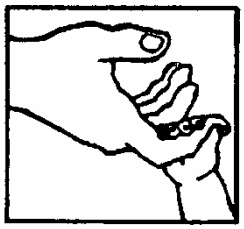
If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **privacy_officer@pediatrix.com** or a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print Name of Patient/Authorized Representative



PEDIATRIC SURGICAL ASSOCIATES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1._____

2. _____

3. _____

4. _____

___ Yes ___No The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

__ Home Voice Mail or Answering Machine Home Phone number: _____

__ Cell phone Cell phone number: _____

__ Work Voice Mail Work phone number: _____

__ **NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____

Print Name of Patient *Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

- o Parent/legal guardian o Power of Attorney

*Evidence of authority must be provided and on file with the practice.