Orange Park Pediatrics

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2140 Smith Street	6353 Argyle Forest Blvd, Ste. #4	1747 Baptist Clay Drive, Ste. #110
Orange Park, FL 32073	Jacksonville, FL 32244	Fleming Island, FL 32003
(904) 269-2140	(904) 908-0200	(904) 520-6620
FAX (904) 264-3018	FAX (904) 908-3915	FAX (904) 215-2981

EMAIL ADDRESS FOR PRACTICE: OPPA@bmcjax.com

Below is a list of items that should be brought to your visit to the office.

- Drivers License
- Insurance Card
- Previous Records including Immunization Record
- Discharge Paperwork if the patient is a newborn or was seen in the ER or Urgent Care Center
- If the patient is being seen for a Behavioral Conference:
    - Behavioral Conference Forms (Available at OrangeParkPediatrics.com)
    - Any previous evaluations

Please plan to arrive at least 15 minutes early to allow us time to process your paperwork.

Orange Park Pediatrics

Date: _______________

Child's Name: ____ Date of Birth: _____________ Age: __________

Drug / Medication Allergies: ____

Current Medications: ____

Past Medical History: *(Please describe any major medical problems and their dates)*

____

____

____

Hospitalizations / Operations (with dates): ____

____

Family History:

ADD/ADHD	NO	YES	PATIENT	FAMILY
Arthritis	NO	YES	PATIENT	FAMILY
Asperger's Syndrome	NO	YES	PATIENT	FAMILY
Asthma	NO	YES	PATIENT	FAMILY
Autism	NO	YES	PATIENT	FAMILY
Bleeding Disorder	NO	YES	PATIENT	FAMILY
Cancer_________________	NO	YES	PATIENT	FAMILY
Developmental Delay	NO	YES	PATIENT	FAMILY
Diabetes Type I / II	NO	YES	PATIENT	FAMILY
Hepatitis B / C	NO	YES	PATIENT	FAMILY
Thyroid Disorder	NO	YES	PATIENT	FAMILY
Mental Illness / Depression	NO	YES	PATIENT	FAMILY
Migraine	NO	YES	PATIENT	FAMILY
Seizure Disorder	NO	YES	PATIENT	FAMILY
Skin Problems	NO	YES	PATIENT	FAMILY
Hypertension	NO	YES	PATIENT	FAMILY
Heart Disease	NO	YES	PATIENT	FAMILY
Genetic Disease___________	NO	YES	PATIENT	FAMILY
Kidney Disease	NO	YES	PATIENT	FAMILY
High Cholesterol	NO	YES	PATIENT	FAMILY
Tuberculosis	NO	YES	PATIENT	FAMILY
Anemia	NO	YES	PATIENT	FAMILY
Auto Immune Disorder	NO	YES	PATIENT	FAMILY
Other____________________	NO	YES	PATIENT	FAMILY

Social History:

Birthplace: ____________________________________ Birth Weight: _______________ Vaginal / C-Section

Members of Immediate Family:

Name	DOB	Relationship
_____________________________	__________	____________________
_____________________________	__________	____________________
_____________________________	__________	____________________
_____________________________	__________	____________________
_____________________________	__________	____________________
_____________________________	__________	____________________

Allergies:

Is the child SENSITIVE / INTOLERANT / ALLERGIC to any of the following foods?

Milk/Dairy Wheat/Gluten Peanuts Say Eggs Corn Yeast Chocolate Citrus Fish/Shellfish Strawberries

Other: ___________________________

Please list any other allergies your child has been diagnosed with or that you suspect:

____

Does anyone in the home smoke? No Yes Type: Cigarettes Cigars Pipes Other ______________

Number/day: _____________

Signature: ____________________________________ Print Name: _____________________________________

Relationship to Patient: _________________________ Date: ____________________

Orange Park Pediatrics

PARENTAL AUTHORIZATION FOR MEDICAL CARE

For families who are ongoing patients of ORANGE PARK PEDIATRICS it may be more convenient to have prior authorization
for medical care delivered to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you wish to authorize treatment in advance.

I/we request and authorize Orange Park Pediatrics and its personnel to deliver medical care to my/our child/children listed below:

PLEASE PRINT CHILD/CHILDREN'S NAME

NAME ___________________________________ DOB ____________________

NAME ___________________________________ DOB ____________________

NAME ___________________________________ DOB ____________________

I/we authorize the following people to bring in my child/children for treatment:

NAME ___________________________________ RELATIONSHIP ___________

NAME ___________________________________ RELATIONSHIP ___________

NAME ___________________________________ RELATIONSHIP ___________

Please try to contact me/us regarding the health care of my/our child/children at the following phone numbers:

PARENTS NAME ____

PHONE ____

PARENTS NAME ____

PHONE ____

OTHER NAME _______________________________ RELATIONSHIP ___________

PHONE ____________________________________

SIGNATURE ________________________________

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/ guardianship with non-parent, etc.), please explain in space below.

____

____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone ______________________

☐ O.K. to leave message with detailed information
☐ Leave message with callback number only

Work Telephone ______________________

☐ O.K. to leave message with detailed information
☐ Leave message with callback number only

Written Communication

☐ O.K. to mail to home address
☐ O.K. to mail to work/office address
☐ O.K. to fax to this number

____

☐ Other ______________________

Patient Name: ______________________ Birthdate ______________________

Parent Signature ______________________ Date ______________________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI, to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

FOR OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax #	Description & Purpose of Disclosure	By Whom Disclosed

Orange Park Pediatrics

MEDICAL RECORDS RELEASE TO ORANGE PARK PEDIATRICS

Records to be sent to the following address:

NAME: Orange Park Pediatrics, Baptist Primary Care
(Please check below the correct address for your selected location.)

	Address				Phone	FAX
○	2140 Smith Street	Orange Park	FL	32073	904/269-2140	904/264-3018
○	6353 Argyle Forest Blvd., #4	Jacksonville	FL	32244	904/908-0200	904/908-3915
○	1747 Baptist Clay Dr., #110	Fleming Island	FL	32003	904/520-6620	904/215-2981

****PLEASE MAIL ALL RECORDS TO ABOVE CHECKED ADDRESS AND FAX IMMUNIZATION TO ASSOCIATED FAX NUMBER.**

Reason for Release of Records: ____

Records to be received from:

Physician/facility: ____

Address: ____

Phone: ______________________________ **Fax:**______________________________

Release from my medical records the following information for the following dates:

From: ______________________ **To:** __________________________

As part of the medical record, the following information will be released unless stricken:

SEXUAL ABUSE INFORMATION, DRUG & ALCOHOL ABUSE INFORMATION, CHILD ABUSE & NEGLECT INFORMATION,

PSYCHIATRIC INFORMATION, AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by Federal law. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed: ____ Date:______________________________

Patient Name: ____________________________________ DOB: ____________ SS#:______________

Witness: ____ Date: ______________________________

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.