PEDIATRICS AT JUBAN

PATIENT INFORMATION FORM

Last Name_____ Prefix____ Suffix____

First Name_____ Middle Initial_____

Date of Birth____/____/____ Age_____Sex ☐M ☐ F

Social Security _____--_____--_____

Race_____ Ethnicity_____

Primary Language_____

Address Line 1_____

Address Line 2 (Apt/Lot#)_____

City_____ State____ Zip_____

Hm Phone _____--_____--_____

Cell Phone _____--_____--_____

Work Phone _____--_____--_____

Mother's Name_____

Mother's Date of Birth_____/_____/_____

Mother's Social Security_____-_____-_____

Father's Name_____

Guardian's Name_____

Insurance Name _____

Member ID, Subscriber ID or Policy #

_____

Insured Party:

Child_____

Other_____

Relationship to Insured_____

Date of Birth_____

Social Security_____--_____--_____

Secondary Insurance Name _____

Member ID, Subscriber ID or Policy #

_____

Insured Party:

Child_____

Other_____

Relationship to Insured_____

Date of Birth_____

Social Security _____--_____--_____

Primary Care Provider _____

Referring Physician_____

Emergency Contact _____

Relationship _____

Phone _____--_____--_____

If needed, can we leave a message?

At home:☐Yes ☐ No On cell: ☐Yes ☐ No

Pharmacy Name_____

Address_____

_____

Phone_____

How did you hear about our office?

Yellow Pages ☐

Friend ☐

Newspaper ☐

Other_____

******PLEASE SHOW ALL INSURANCE CARDS TO CHECK-IN STAFF******

Rev 09/23/2022

PEDIATRICS AT JUBAN

Medical Information Release Form (HIPAA Release Form)

Child's/Patient Name: _____

Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to my child/myself and claims information.
This information may be released to:

[ ] Parent/ Guardian_____

[ ] Other_____

[ ] Other_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages to Reschedule Appointment, regarding Medical care or Emergency:
PLEASE PROVIDE CORRECT AND WORKING NUMBERS
Please call
[ ] my home: _____

[ ] my work: _____

[ ] my cell number: _____

If unable to reach me:
[ ] you may leave a detailed message.
[ ] please leave a message asking me to return your call.
[ ] Do not leave a message.
The best time to reach me is (day) _____ between (time) _____

Patient/Parent/Guardian:

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Patient Portal Authorization Form

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that our practice has your **correct e-mail address** and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print Patient Name: _____ DOB: _____

Print Patient Name: _____ DOB: _____

Print Patient Name: _____ DOB: _____

Print Patient Name: _____ DOB: _____

Print Patient Name: _____ DOB: _____

Patient/Parent/Guardian Signature: _____

Date: _____

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years. Name of Parent/Guardian requesting access:

_____

Print Name of Parent/Guardian

_____

Relationship to the Patient Date

Our Patient Portal site may be accessed by using the following URL: (enter exactly like below)

https://health.healow.com/PEDICONS

Please download the HEALOW APP TO YOUR SMARTPHONE

PRACTICE CODE FOR HEALOW APP: EAECAD

PEDIATRICS AT JUBAN

Authorization to Release Health Information
(Including paper, oral and electronic information)

By signing this form, I authorize you to release confidential health information about my child's/myself, by releasing a copy of my medical records, or a summary or narrative of my child's/myself protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____**DOB:**_____

Parent/Guardian:_____

Purpose of Release: □ Medical □ Insurance □Legal □ Other _____

Put an "X" in box for items to be released.

□ **Complete Records**
□ Lab Reports
□ Radiology Reports
□ Pathology Reports
□ Care Plan
□ Hospital/Operative Reports
□ Progress Notes
□ Medication Record
□ History & Physical
□ Other (please state)
_____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

□ HIV/AIDS
□ Sexually Transmitted Diseases
□ Mental Health
□ Drug Abuse
□ Psychotherapy Notes
□ Alcoholism
□ Genetics
□ Other (please state)
_____

I authorize the following persons to make these disclosures of my health information:

Name:_____

Address:_____

Phone:_____

Fax:_____

I authorize the following persons to receive these disclosures of my health information:

PEDIATRICS AT JUBAN 10130 Crossing Way STE 335 Denham Springs, LA 70726

(O) 225-667-2777 (F) 225-667-0064

This authorization shall expire on _____**(date or event).**
I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

Signature of Patient/Parent/or Guardian:

_____ Date:_____

Rev 07/29/2022

PEDIATRICS AT CENTRAL

PEDIATRICS AT JUBAN

PEDIATRICS AT DELMONT

Release of information signature form:

By signing this form, I (patient/guardian) am stating that I have read and/or completed the following:

- Health Insurance
- Patient's Rights and Responsibilities
- Prescription History Release
- Release of Medical Information Form

I (patient/guardian) understand or have had the opportunity to ask questions regarding the forms.

You also have a right to reeive a copy of this form after you have signed it.

Date: _____

Print Patient Name: _____

Patient DOB: _____

Signature of Patient/Guardian: _____

Relationship to Patient: _____