Patient and Family Information

PHARMACY PREFERENCE_____
FULL NAME_____
ETHNICITY (OPTIONAL)_____ **MALE** **FEMALE**
DOB_____**SS#**_____**PLACE OF BIRTH**_____

PARENT/GUARDIAN INFORMATION
FATHER_____**DOB**_____**SS#**_____
MAILING ADDRESS_____
CITY,STATE_____**ZIP**_____
HOME PHONE_____**CELL PHONE**_____
EMPLOYER_____
EMPLOYER ADDRESS _____**WORK PHONE**_____
EMAIL(S)_____

MOTHER_____**DOB**_____**SS#**_____
MAILING ADDRESS_____
CITY,STATE_____**ZIP**_____
HOME PHONE_____**CELL PHONE**_____
EMPLOYER_____
EMPLOYER ADDRESS _____**WORK PHONE**_____
EMAIL(S)_____

Emergency Contact(s) (NOT at the same address)

NAME_____**RELATIONSHIP**_____**PHONE#**_____

NAME_____**RELATIONSHIP**_____**PHONE#**_____

Insurance Information
PRIMARY INSURANCE COMPANY NAME_____
POLICY #_____**GROUP#**_____
POLICY HOLDER NAME_____**DOB**_____**RELATIONSHIP**_____

SECONDARY INSURANCE COMPANY NAME_____
POLICY #_____**GROUP#**_____
POLICY HOLDER NAME_____**DOB**_____**RELATIONSHIP**_____

SIBLING/S:_____
_____

I AUTHORIZE TREATMENT OF THE PATIENT NAMED ABOVE AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY INSURANCE OR NOT. I HEREBY AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS AND ASSIGN BENEFITS TO **IORGA PEDIATRICS LLC.**

SIGNATURE OF PATIENT/LEGAL GUARDIAN_____**DATE**_____

Patient Name: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND CONSENT

The Notice of Privacy Practices tells you how we may use and share your health records. **Please read the following.**

- We will use and share your health records to provide medical treatment to you.
- We will use and share your health records to bill the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we use and share your medical records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your medical records.

- You have the right to look at and receive a copy of your medical records.
- You have the right to ask us to correct a mistake in your medical records.
- You have the right to ask for a list of disclosures for your medical records.
- You have the right to ask that we not use or share your medical records.
- You have the right to ask us to change the way we contact you.

These rights are explained in more detail in the notice of Privacy Practices (available upon request).

I understand my rights listed above and in the Notice of Privacy Practice.

Signature:_____ Date:_____
(Of Patient or Legal Representative)

Capacity of Legal Representative (if applicable)*:_____

Staff only: if patient did not or could not, acknowledge receipt of the Notice, indicate why:

_____

I **consent** to the use and sharing of my medical records for treatment, payment, and operations purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide any services to me.
Oklahoma law requires that we advise you that the **information authorized for disclosure MAY include information which may be considered a communicable or venereal disease, including but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).** It also **MAY** include mental health or other sensitive information.

Signature:_____ Date:_____
(Of Patient or Legal Representative)

Capacity of Legal Representative (if applicable)*:_____

*You may be requested to provide verification of representative status.