Orlando Pediatrics
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New PatientRegistrationPacket

(Rev. 02/01/13)

Patient Name _____ Home Phone _____
Birthday _____ Male_____ Female_____
Age _____SS#_____Race_____ Ethnicity_____
Address _____ City_____State_____Zip_____

Parent/Guardian Information

Mother/Guardian_____DOB_____Phone_____
SS#_____ DL#_____State of DL_____
Address_____City_____State____Zip_____
Occupation _____ Employer_____Phone_____
Required*E-mail_____
Father/Guardian _____DOB_____ Phone_____
SS#_____ DL#_____State of DL_____
Address_____City_____State____Zip_____
Occupation _____ Employer_____ Phone_____
Required *E-mail_____

Emergency Contact Information (other than parent/guardian)

Contact Name_____Realtionship_____
Address_____City_____State_____Zip_____
Home Phone_____ Work Phone_____

-Is this person authorized to bring the child in? [ ] yes [ ] no

-Is this person authorized to be given medical records? [ ] yes [ ] no

-Is this person authorized to make appointments and receive patient information over the phone and/or messages? [ ] yes [ ] no

Consent for Treatment

I have the legal right to give consent to the Physicians of Orlando Pediatrics to treat this child. I also give the physicians of Orlando Pediatrics consent to retrieve medication history from third party sources. I understand this consent will be valid during the entire term of care; furthermore, I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me for my child as a result of examinations. I also understand my child's photo will be taken for the strict purpose of identifying within the practice and will not be released to external sources.

_____ _____ _____ _____
(Printed Name) (Signature) (Date)(Relation)