WELCOME
NEWTOWN CENTER PEDIATRICS

Laura Nowacki, MD
Jennifer Burns, APRN
Emilie Koepke Gibbs, PA-C
10 Queen Street
Newtown, CT 06470
(203) 426-3267

TODAY'S DATE ____________________

PATIENT(S) INFORMATION

PATIENT NAME____MALE ☐ FEMALE ☐ DOB__________
RACE ☐ BLACK ☐ WHITE ☐ ASIAN ☐ DECLINED TO SPECIFIY ☐ OTHER _____________
ETHNICITY ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO ☐ DECLINED TO SPECIFY
PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____________

PATIENT NAME____ MALE ☐ FEMALE ☐ DOB__________
RACE ☐ BLACK ☐ WHITE ☐ ASIAN ☐ DECLINED TO SPECIFIY ☐ OTHER _____________
ETHNICITY ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO ☐ DECLINED TO SPECIFY
PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____________

PATIENT NAME____ MALE ☐ FEMALE ☐ DOB__________
RACE ☐ BLACK ☐ WHITE ☐ ASIAN ☐ DECLINED TO SPECIFIY ☐ OTHER _____________
ETHNICITY ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO ☐ DECLINED TO SPECIFY
PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____________

PATIENT NAME____ MALE ☐ FEMALE ☐ DOB__________
RACE ☐ BLACK ☐ WHITE ☐ ASIAN ☐ DECLINED TO SPECIFIY ☐ OTHER _____________
ETHNICITY ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO ☐ DECLINED TO SPECIFY
PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____________

INSURANCE INFORMATION

****PLEASE PRESENT CARD AT EVERY VISIT****

INSURANCE COMPANY________________________________ EFFECTIVE DATE ___________________________

IDENTIFICATION #____________________________________ GROUP #_________________________________

POLICY HOLDER'S NAME _____________________________ POLICY HOLDER'S DOB________________________

POLICY HOLDER'S ADDRESS ____

PLEASE COMPLETE BOTH SIDES →

PARENT INFORMATION

PARENT 1

NAME_____DOB _____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME NUMBER (_____)_____ - _____ CELL NUMBER (_____) _____ - _____

EMAIL_____

PARENT 2

NAME_____DOB _____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME NUMBER (_____)_____ - _____ CELL NUMBER (_____) _____ - _____

EMAIL_____

HIPAA RELEASE & CONSENT

I GIVE NEWTOWN CENTER PEDIATRICS <u>PERMISSION</u> FOR THE FOLLOWING:

- TO SEND APPOINTMENT REMINDERS VIA TEXT AND/OR EMAIL.
- TO LEAVE A DETAILED MESSAGE ON THE FOLLOWING PHONE #'S (PLEASE CHECK ALL THAT APPLY)

CELL ☐ HOME ☐ WORK ☐ OTHER ☐ _____

SIGNATURE_____DATE_____/_____/_____RELATIONSHIP_____

PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that I have received a copy of Newtown Center Pediatrics **NOTICE OF PRIVACY PRACTICES** (See attached). I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this notice should it be modified in any way.

I also hereby acknowledge that I have received a copy of the **YOUR RIGHTS REGARDING THE ELECTRONIC SHARING OF HEALTH INFORMATION OPT-OUT INFORMATION** (see attached). I understand that if I have any questions or wish to opt-out of the HIE I should visit www.cthealthlink.com.

SIGNATURE_____DATE_____RELATIONSHIP TO PATIENT_____