SEASIDE PEDIATRICS OF KEY WEST

NEW PATIENT REGISTRATION

1075 Duval St., Unit C-14 | Key West, FL 33040
Phone: (305) 295-7337 | Fax: (305) 295-0597
info@seasidepediatricskw.com | seasidepediatricskw.com

Patient demographics and guardians

PATIENT DEMOGRAPHICS

Patient legal name (last, first, middle) | Preferred name | Date of birth

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex | Gender identity (optional) | Pronouns (optional)

Home address

City | State | ZIP code | County

Primary language | Interpreter needed? ☐ Yes ☐ No | Race / ethnicity (optional)

PARENT / GUARDIAN 1

Full legal name | Relationship to patient | Date of birth

Home phone | Mobile phone | Work phone | Email

Address, if different from patient

PARENT / GUARDIAN 2

Full legal name | Relationship to patient | Date of birth

Home phone | Mobile phone | Work phone | Email

Address, if different from patient

COMMUNICATION PREFERENCES

Preferred contact: ☐ Call ☐ Text ☐ Email | Preferred number / email | May leave voicemail? ☐ Yes ☐ No

Names of persons authorized to discuss care / receive patient information (optional)

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Insurance, contacts, pharmacy, providers

PRIMARY INSURANCE

Insurance company / plan

Member / policy ID

Group number

Subscriber name

Subscriber date of birth

Relationship to patient

Subscriber address, if different

Insurance phone

SECONDARY INSURANCE (IF APPLICABLE)

Insurance company / plan

Member / policy ID

Group number

Subscriber name

Subscriber date of birth

Relationship to patient

EMERGENCY CONTACT (NOT A PARENT / GUARDIAN LISTED ON PAGE 1)

Full name

Relationship

Phone

PREFERRED PHARMACY

Pharmacy name

Phone

Fax (if known)

Address / location

PRIMARY CARE / REFERRING PROVIDER

Current / previous pediatrician or primary care clinician

Phone

Fax

Practice name and address

Referring provider, if different

Phone

Fax

RESPONSIBLE PARTY / BILLING CONTACT

Name

Relationship

Phone

Billing address, if different

Email

INSURANCE CARD REMINDER

Please provide current insurance card(s) and a photo ID for the responsible adult. Coverage verification is not a guarantee of payment. Notify the practice promptly if insurance or contact information changes.

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MEDICAL HISTORY SUMMARY

Reason for establishing care / current concerns

Birth history / pregnancy or delivery concerns (include gestational age, birth weight, NICU stay if relevant)

Significant diagnoses, hospitalizations, surgeries, injuries, or specialist care

Developmental, behavioral, learning, or school concerns

Family medical history (heart disease, sudden death, asthma, diabetes, seizures, genetic conditions, mental health, other)

Immunization status

☐ Current ☐ Incomplete / delayed ☐ Unknown

Records available?

☐ Yes ☐ No

ALLERGIES

☐ No known allergies

List medication, food, environmental, or other allergies and reactions

CURRENT MEDICATIONS

☐ No current medications

List prescription, over-the-counter, vitamins, supplements, dose and frequency

ADDITIONAL INFORMATION

Other information the clinical team should know

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NEW PATIENT REGISTRATION

Acknowledgments, consent, and signatures

CONSENT ACKNOWLEDGMENTS

- ☐ Consent for care: I authorize the practice's clinicians and staff to evaluate and treat the patient, including routine examinations, diagnostic procedures, and treatment considered appropriate within the scope of the visit.
- ☐ Financial responsibility: I understand that I am responsible for charges not paid by insurance, including deductibles, copayments, coinsurance, non-covered services, and charges arising from inaccurate or outdated insurance information.
- ☐ Insurance benefits and information: I authorize release of information needed to process claims and assign applicable insurance benefits directly to the practice, where permitted.
- ☐ Care coordination: I authorize the practice to obtain and share relevant medical information with other health care providers, pharmacies, laboratories, and health plans for treatment, payment, and health care operations, as permitted by law.
- ☐ Electronic communications: I understand that ordinary email and text messaging may have privacy risks. I authorize the practice to use the contact methods selected on page 1 for appointment and care-related communications, subject to practice policy.

HIPAA / PRIVACY ACKNOWLEDGMENT

- ☐ I acknowledge that I have received, reviewed, or been offered the practice's Notice of Privacy Practices. I understand that the notice describes how health information may be used or disclosed and explains patient privacy rights. I understand that I may request a paper copy.

Name of person acknowledging

Relationship to patient

CERTIFICATION AND SIGNATURES

By signing below, I certify that the information provided in this registration form is complete and accurate to the best of my knowledge. I agree to notify the practice of material changes. I understand that practice-specific policies and any additional consent forms provided by the practice also apply.

Parent / guardian / authorized representative signature

Date

Printed name

Relationship to patient

Second parent / guardian signature (if required)

Date

Printed name

Relationship to patient

FOR PRACTICE USE ONLY

Medical record number

Registration date

Verified by

Insurance cards copied ☐ Yes ☐ No

Photo ID verified ☐ Yes ☐ No

Privacy notice provided ☐ Yes ☐ No

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DETAILED PEDIATRIC MEDICAL HISTORY

Birth, development, and health history

PATIENT INFORMATION

Patient legal name (last, first, middle)

Date of birth

Medical record no. (office)

Person completing form

Relationship

Date completed

PREGNANCY AND BIRTH HISTORY

Gestational age at birth

Birth weight

Delivery ☐ Vaginal ☐ C-section

Multiple birth? ☐ Yes ☐ No

Pregnancy, delivery, newborn, jaundice, feeding, or NICU concerns

GROWTH AND DEVELOPMENT

Developmental milestones / age when achieved, if known

Current developmental, speech, motor, sensory, behavior, learning, or school concerns

School / daycare name and grade

IEP / 504 / therapies? ☐ Yes ☐ No

NUTRITION, SLEEP, AND SOCIAL HISTORY

Diet, feeding, appetite, supplements, or food access concerns

Sleep routine, snoring, or sleep concerns

Household members / living arrangement

Smoke / vape exposure? ☐ Yes ☐ No

Pets / firearms / other safety information

SEASIDE PEDIATRICS OF KEY WEST

DETAILED PEDIATRIC MEDICAL HISTORY

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Conditions, medications, and family history

PAST AND CURRENT MEDICAL HISTORY

☐ Asthma / wheezing		☐ Allergies / eczema	
☐ Heart condition / murmur		☐ Seizures / neurologic condition	
☐ Diabetes / endocrine condition		☐ Kidney / urinary condition	
☐ GI / feeding condition		☐ Vision / hearing problem	
☐ Mental / behavioral health		☐ Genetic / congenital condition	
☐ Recurrent infections		☐ Other chronic condition	

Hospitalizations, surgeries, serious illnesses, injuries, or specialist care (include dates)

ALLERGIES AND MEDICATIONS

☐ No known allergies

Allergies and reactions

☐ No current medications

Medication / dose / frequency / reason

FAMILY MEDICAL HISTORY

For each condition, identify affected relative(s)

Include: early heart disease or sudden death, asthma/allergy, diabetes, seizures, genetic conditions, cancer, mental health, substance use, or other significant history.

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Review, immunizations, and certification

REVIEW OF SYSTEMS AND ADDITIONAL INFORMATION

Current symptoms or health concerns

Dental health and dental home

Vision or hearing concerns

Menstrual history, if applicable

Behavioral / emotional health concerns

Other information for the clinical team

IMMUNIZATIONS AND RECORDS

☐ Immunizations current ☐ Delayed / incomplete ☐ Unknown ☐ Records attached

Previous pediatrician / practice | Phone | Fax

CERTIFICATION

I certify that the information provided is complete and accurate to the best of my knowledge. I will notify the practice of important changes and understand that clinical staff may ask follow-up questions.

Parent / guardian / authorized representative signature | Date

Printed name | Relationship to patient

SEASIDE PEDIATRICS OF KEY WEST

PEDIATRIC SOCIAL HISTORY

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Home, family, and social environment

PATIENT INFORMATION

Patient legal name (last, first, middle)

Date of birth

Date completed

Person completing form

Relationship to child

FAMILY AND CHILDCARE

Parents / caregivers in the child's household (check all that apply)

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent ☐ Other

Parents' marital / relationship status

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Other

Daycare / preschool / school attendance

☐ Yes ☐ No

Name and schedule, if applicable

HOME ENVIRONMENT

Home type

☐ House ☐ Apartment ☐ Condo / townhome ☐ Temporary housing ☐ Other

Water source

☐ City / public ☐ Well ☐ Bottled / filtered ☐ Other

Smoking or vaping in the home / car

☐ Yes ☐ No

Who / where?

Pets in the home

☐ Yes ☐ No

Type and number

Known mold, mildew, water damage, pests, or other environmental concerns

☐ Yes ☐ No

CHILD / ADOLESCENT SOCIAL HISTORY

This information pertains to the child. If not applicable, leave it blank. The clinical team may review sensitive questions privately when appropriate.

Alcohol, tobacco, vaping, marijuana, or other drug use

☐ Yes ☐ No

Details, if applicable

SEASIDE PEDIATRICS OF KEY WEST

PEDIATRIC SOCIAL HISTORY

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Sibling and additional household information

CHILD / ADOLESCENT QUESTIONS - CONTINUED

Sexually active ☐ Yes ☐ No ☐ Prefer not to answer

SIBLINGS

Name	Date of birth	Sex		Lives with child?
		☐ M	☐ F	☐ Yes
		☐ M	☐ F	☐ Yes
		☐ M	☐ F	☐ Yes
		☐ M	☐ F	☐ Yes
		☐ M	☐ F	☐ Yes
		☐ M	☐ F	☐ Yes

ADDITIONAL HOUSEHOLD INFORMATION

Other children or adults living in the home, including relationship to the child

Recent family changes, moves, separations, losses, stressors, or safety concerns

REVIEW

Parent / guardian / patient printed name

Date

Additional comments

SEASIDE PEDIATRICS OF KEY WEST

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

1075 Duval St., Unit C-14 | Key West, FL 33040
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Release records to Seaside Pediatrics

PATIENT INFORMATION

Patient legal name (last, first, middle)

Date of birth

Medical record no. (office)

Patient address

Phone

PROVIDER / FACILITY RELEASING RECORDS

Provider or facility name

Phone

Fax

Address

RECIPIENT

Send records to: Seaside Pediatrics of Key West, 1075 Duval St., Unit C-14, Key West, FL 33040 | Fax: (305) 295-0597 | Email: info@seasidepediatricskw.com

RECORDS REQUESTED

- ☐ Complete medical record
- ☐ Immunization record
- ☐ Growth charts
- ☐ Visit notes
- ☐ Medication list
- ☐ Allergy list
- ☐ Laboratory results
- ☐ Imaging / diagnostic reports
- ☐ Hospital / operative records
- ☐ Specialist reports
- ☐ Developmental / behavioral records
- ☐ Other

Other / date range / specific details

Purpose

- ☐ Continuity of care
- ☐ Transfer of care
- ☐ Other

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Authorization and signature

AUTHORIZATION

I authorize the provider or facility identified above to disclose the selected records to Seaside Pediatrics of Key West. I understand that this authorization is voluntary; treatment, payment, enrollment, or eligibility for benefits generally may not be conditioned on signing it except as permitted by law.

This authorization expires one year from the signature date unless an earlier date or event is entered below. I may revoke it in writing, except to the extent action has already been taken in reliance on it. Information disclosed may be subject to redisclosure and may no longer be protected by federal privacy rules.

Earlier expiration date or event (optional)

Initial if authorization includes specially protected information, where applicable:

Mental / behavioral health

Substance-use treatment

HIV / AIDS-related

SIGNATURE

Parent / guardian / authorized representative signature

Date

Printed name

Relationship to patient

If signed by a personal representative, describe authority and attach documentation if required

SEASIDE PEDIATRICS OF KEY WEST

OFFICE POLICIES AND NO-SHOW ACKNOWLEDGMENT

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Practice expectations and acknowledgment

PATIENT INFORMATION

Patient legal name (last, first, middle)

Date of birth

Medical record no. (office)

APPOINTMENTS AND ARRIVAL

Please arrive on time and bring current insurance cards, identification, medication information, and requested records. Late arrival may require a shortened visit or rescheduling so other patients can be seen safely and on time.

Practice cancellation notice requirement

24 hours' advance notice

Late cancellation / no-show fee

$20 fee

CANCELLATIONS AND MISSED APPOINTMENTS

Notify the practice as early as possible if an appointment cannot be kept. Repeated late cancellations or missed appointments may affect scheduling options or the patient-practice relationship, consistent with practice policy and applicable law. Emergencies and exceptional circumstances may be reviewed by the practice.

☐ I acknowledge the cancellation and missed-appointment policy stated above.

INSURANCE AND PAYMENT

Insurance information must be current. Copayments and other patient-responsibility amounts may be due at the time of service. Insurance verification is not a guarantee of payment. The responsible party remains responsible for deductibles, coinsurance, non-covered services, and balances not paid by insurance, subject to applicable agreements and law.

☐ I acknowledge the insurance and payment policy stated above.

PRESCRIPTION REFILLS, FORMS, AND MESSAGES

Routine refill requests, school or camp forms, referrals, and non-urgent messages require reasonable processing time. Some requests may require an examination or current preventive visit. Urgent symptoms should not be sent through email, text, or routine portal messages; call the practice or seek emergency care as appropriate.

☐ I acknowledge the refill, form, and messaging expectations stated above.

COMMUNICATION AND PRIVACY

Keep contact information and authorized-person designations current. The practice uses reasonable safeguards, but ordinary voicemail, email, and text may carry privacy risks. Communication preferences do not replace emergency services or guarantee immediate review.

☐ I acknowledge the communication and privacy expectations stated above.

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OFFICE POLICIES AND NO-SHOW ACKNOWLEDGMENT

Acknowledgment and signatures

PATIENT SAFETY AND RESPECTFUL CONDUCT

Accurate health information, respectful communication, and appropriate supervision of children help maintain a safe environment. Threatening, abusive, discriminatory, or disruptive conduct may be addressed under practice policy. Weapons, smoking, vaping, alcohol, and illegal drugs are not permitted on practice premises, subject to applicable law.

☐ I acknowledge the safety and respectful-conduct expectations stated above.

ACKNOWLEDGMENT

I acknowledge that I received or reviewed these office policies, had an opportunity to ask questions, and understand that the practice may update its policies. I understand that this acknowledgment supplements, and does not replace, other registration, consent, privacy, and financial documents.

☐ I acknowledge and agree to follow the office policies described in this document.

Parent / guardian / authorized representative signature

Date

Printed name

Relationship to patient

Additional parent / guardian comments or questions

FOR PRACTICE USE ONLY

Policy version / effective date

Staff witness / reviewer

Date