CENTRAL OHIO PRIMARY CARE
FAMILY PRACTICE CENTER OF WESTERVILLE
190-A South State Street • Westerville, Ohio 43081-2200 • www.fpcw.net • (614) 882-2349 • Fax 614-882-9005
CAROL C. HOSTETTER, D.O. • ANN H. CALLAND, D.O. • ANDREW P. EILERMAN, D.O.

PATIENT REGISTRATION FORM - PEDIATRIC / TODDLER / ADOLESCENT

PATIENT'S FULL LEGAL NAME ______________________________ NICK NAME ____________________
PLEASE PRINT IF ANY

PATIENT'S SS# ____________________ M ____ F ____ DATE OF BIRTH ______/______/________

ADDRESS ____

CITY ____________________ ST ________ ZIP __________ PARENT HOME PHONE (______) ______________

PARENT'S FULL LEGAL NAMES: RACE ___White ___Black ___Hispanic ___Asian ___Other______

FATHER ______________________________ MOTHER ______________________________
PLEASE PRINT PLEASE PRINT

PARENT WORK PHONE (_____) ______________ Mom__ Dad__ PARENT CELL PHONE (_____) ______________ Mom__ Dad__

WHO BESIDE THE PARENT(S) LISTED ABOVE MAY 1. BRING THIS CHILD FOR TREATMENT OR 2. RECEIVE INFORMATION CONCERNING THE HEALTH OF THIS CHILD? List name, phone number & relationship Such as step parent/grandparent

NAME PHONE NUMBER RELATIONSHIP TO PATIENT

____

INFORMATION ON FAMILY MEMBER CARRYING THE INSURANCE

FULL LEGAL NAME ______________________________ RELATIONSHIP TO PATIENT ____________________

ADDRESS IF DIFFERENT FROM ABOVE ____

RESPONSIBLE PARTY DATE OF BIRTH _____/______/________ RESPONSIBLE PARTY SS# ____________________

HOME PHONE (______) ______________ CELL PHONE (______) ______________ WORK PHONE (______) ______________

INFORMATION ON PARTY RESPONSIBLE FOR PAYMENT OF BALANCE (If Different from Insurance Carrier)

FULL LEGAL NAME ______________________________ RELATIONSHIP TO PATIENT ____________________

ADDRESS IF DIFFERENT FROM ABOVE ____

RESPONSIBLE PARTY DATE OF BIRTH _____/______/________ RESPONSIBLE PARTY SS# ____________________

HOME PHONE (______) ______________ CELL PHONE (______) ______________ WORK PHONE (______) ______________

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Central Ohio Primay Care — Family Practice Center of Westerville, for the purpose of diagnosis or providing treatment to me, obtailing payment for my health care and to conduct health care operations. I understand that diagnosis and treatment of me by Family Practice Center of Westerville, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Family Praclice Center of Westerville is not required to agree to the restrictions that I may request. However, if Family Practice Center of Westerville agrees to a restriction that I request, the restriction is binding on Central Ohio Primary Care — Family Practice Center of Westerville.

I have the right to revoke this consent, in writing, at any time, except to the extent that Central Ohio Primary Care — Family Practice Center of Westerville has taken action in reliance on this consent.

My "protected health information" means health information, including any demographic information collected from me or received by my physician, another health care provider, my employer or health care clearinghouse. This protected health information related to my past present and future physical or mental heatth or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to have provided to me and review Central Ohio Primary Care — Family Practice Center of Westerville, our Notice of Privacy Practices before signing this document The Notice of Privacy Practices is also posted for review in the reception area. This notice describes the types of uses and disclosures of protected health information that will occur in my treatment, payment of my bills or in the practice of health care operations of the practice.

Central Ohio Primary Care — Family Practice Center of Westerville reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by call the office and requesting that a revised copy be sent to me or asking for one at the time of my next appointment.

DO WE HAVE A RELEASE OF INFORMATION ON FILE FOR YOU? ☐Y ☐N (Obtained__________) MYSIS_______ PHI_______

______________________________ ______________________________________ _____/______/________
Signature of patient or personal representative Description of personal representative authority: Self, Parent, POA Date