

P# \_\_\_\_\_

**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.

Dr# \_\_\_\_\_

**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 HEALTHCARE 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, obtaining 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 Praclce 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 health 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.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of patient or personal representative Description of personal representative authority: Self, Parent, POA Date

P# \_\_\_\_\_

Dr# \_\_\_\_\_

**PEDIATRIC (UNDER 18)  
REQUEST FOR CONFIDENTIAL COMMUNICATION  
PLEASE COMPLETE EVERY SECTION FULLY!**



**I hereby request to receive confidential communications from the practice in the following manner:**

**(Please Print)**

Patient — Full Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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Mother's Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

May we contact you at your Home Cell via our housecalls for a appointment reminder? Yes No

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**You may also communicate my child's protected health information with the following:**

**(Please Print)**

Other: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address where I would like my child's protected health information mailed to:

Street \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

You may leave limited protected health information on a voicemail or answering machine of the names listed above (lab or test results, information about scheduling or prep for a test or procedure or information regarding follow up with a specialist)

Yes \_\_\_\_\_ No \_\_\_\_\_

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**I understand COPC will notify me if COPC is unable to comply with my request. I also understand that my child's protected health information may be released as my physician determines appropriate in an emergency situation.**

**I have been offered the office Notice of Privacy Practices for COPC Yes \_\_\_\_\_ No \_\_\_\_\_**

Signature of patient/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(if over the age of 18/if under the age of 18)

**(Please Print)**

Name of person signing: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Office Use Only**

Date received: \_\_\_\_\_ Entered into Mysis: \_\_\_\_\_ Entered into IC: \_\_\_\_\_

Initials: \_\_\_\_\_