OPTIMAL CARE PEDIATRICS
MONIQUE MONDESIR, MD
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NEW PATIENT REGISTRATION FORM

Primary Parent/Guardian Information

Parent/Guardian Name: _____ DOB _____ Sex: __

Relationship to patient _____ Lives with patients below ___ SSN_____

Primary address _____

City _____ State _____ Zip _____

Primary phone _____ Work phone _____ Cell phone _____

Employer: _____ Occupation _____

Personal e-mail _____

Pharmacy name: _____Phone: _____ Fax: _____

Preferred contact method for:

Medical issues _____ Reminders _____ Recalls _____

Billing statements _____ General notices _____ Patient Portal _____

Secondary Parent/Guardian Information (optional)

Parent/Guardian Name: _____ DOB _____ Sex: __

Relationship to patient _____ Lives with patients below ___ SSN_____

Primary address _____

City _____ State _____ Zip _____

Primary phone _____ Work phone _____ Cell phone _____

Employer: _____ Occupation _____

Personal e-mail _____

Pharmacy name: _____Phone: _____ Fax: _____

Preferred contact method for:

Medical issues _____ Reminders _____ Recalls _____

Billing statements _____ General notices _____ Patient Portal _____

Child 1

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 2

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 3

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Child 4

Patient/Child Name: _____ DOB: _____ Sex: ___

Primary address _____

City _____ State _____ Zip _____

Emergency contact: _____

Primary phone _____ Personal email address _____

Language _____ Ethnicity _____ Race _____

Primary Insurance

Subscriber's Name: _____ DOB _____ Sex: __

Subscriber ID#:_____ Patient relationship to subscriber _____

Insurance carrier _____ Group #:_____ Group name: _____

Authorized persons other than parent/guardian

Persons other than parent/guardian who are authorized to accompany child to appointment include:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Note: These persons are required to bring photo ID on the day of the appointment

Patient Authorization for ePRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescriptions directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of Optimal Care Pediatrics to enroll my child in the ePrescribe Program.

Patient signature _____ Date _____

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of Optimal Care Pediatrics to request and obtain my child's prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

Patient signature _____ Date _____

Patient Agreement to Adhere to Scheduled Vaccines

I understand that it is the policy of Optimal Care Pediatrics that all patients must adhere to the CDC and AAP recommended vaccination schedule. A schedule of all vaccines can be found on the Optimal Care Pediatrics website. I agree to be compliant with the scheduled vaccines requirement and understand that failure to do so could prevent me from continuing care at Optimal Care Pediatrics.

Patient signature _____ Date _____

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of Optimal Care Pediatrics to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to OPTIMAL CARE PEDIATRICS the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature _____ Date _____

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and Optimal Care Pediatrics to photograph me for medically related documentation purposes.

Patient signature _____ Date _____

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Optimal Care Pediatrics of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Optimal Care Pediatrics is the patient's responsibilities.

Patient signature _____ Date _____