Fast Track Pediatrics
1133 18TH PLACE
OCALA, FL 34471
REGISTRATION FORM

Patient's Name: _____ DOB _____ Gender _____ Age _____

Patient's Social: _____ Name of Primary Doctor _____ Tel # _____

Patient's Guardian _____ DOB _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Tel _____ Cell _____ Work # _____

Race _____ Ethnicity _____ Preferred Language _____

Insurance Name _____ ID # _____ Group # _____

CONSENT FOR TREATMENT

I consent to the medical treatment of Fast Track Pediatrics by its Doctors, Nurse Practitioners, and Staff. I authorize and consent to any necessary or routine medical or surgical treatment.

I give consent to Fast Track Pediatrics to use and disclose my protected health information for the purpose of treatment, payment and healthcare operations. "Protected Health Information," means health information including demographics collected from me or received by my physician, another health care provider. This information may also relate to my past, present or future physical or mental health condition. The Notice of Privacy Practices provides more detailed information. You have the right to review it before you sign this consent form.

I understand that any person other than the Parent or Guardian bringing the child in for medical treatment must have a signed and dated letter of consent from the Parent or Guardian.

Parents/Guardian's _____

Signature _____ Date _____

I understand that I may be billed or held responsible for the full balance for services rendered if the expense is not covered by patient' Insurance or patient is not eligible for coverage at the time of service. I will also be responsible for all expenses including attorney's f paid by Fast Track Pediatrics in collecting this obligation by suit or otherwise the entire amount is due and payable upon billing.

Full payment of Co-pays, Deductibles, Self-pays and co-insurance are required at the time of service. We accept credit/debit cards and Cash Only. Checks are not accepted.

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Fast Track Pediatrics Notice of Private Practices.

Parents/Guardian's Name _____

Signature _____ Date _____

Fast Track Pediatrics

Pediatric Health History

Patient Name: _____ D.O.B. _____ Sex: _____

AGE : 0 - 5 YEARS ONLY	AGE : 0 - 21 YEARS				
PRENATAL HISTORY		Patient	Parents	Grandparents	Siblings
Prenatal Care:	Asthma				
Birth Wt LB OZ	Medic. Allergies				
Length	Diabetes				
APGARS	Lung Disease				
Vaginal Delivery Y / N CS Y N	Cancer				
Pre term Y / N Post term Y N	Heart Disease				
Full term Y N DeformitiesY N	Hypertension				
Jaundice Y / N	Allergie$				
Breast Y/N Formula Y / N	Epilepsy				
	Bleeding Disorder				
	Kidney disease				
	Birth defects				
	Mental Illness				
	Smoking				

HOSTPITALIZATION/SURGERY

DATE	REASON

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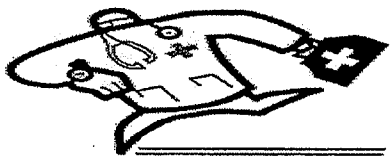

CHILD'S NAME: _____ DOB: _____

PLEASE CHECK ONE EACH

RACE:

- o CAUCASIAN
- o BLACK
- o ASIAN
- o AMERICAN INDIAN
- o HISPANIC
- o PACIFIC ISLANDER
- o OTHER
- o REFUSED

ETHNICITY:

- o HISPANIC OR LATINO
- o NOT HISPANIC OR LATINO
- o REFUSED

LANGUAGE:

- o ENGLISH
- o SPANISH
- o FRENCH
- o OTHER
- o REFUSED

PARENT/GUARDIAN NAME PRINT: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN EMAIL: _____

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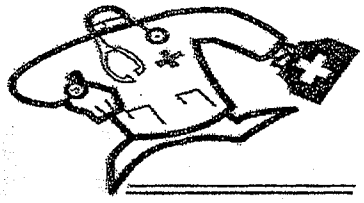

Please fill in Patients Information and at least phone number of your preferred Pharmacy.

Patient's Name: _____ **DOB:** _____

Pharmacy Name: _____

Address: _____

_____

_____

Phone Number: _____

PARENT/ GUARDIAN EMAIL: _____