Grello Pediatrics
Patient Registration

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White/ Unknown

Child 4: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White/ Unknown

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____

MOTHER: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No

Home Phone: (_____)_____-_____ Cell Phone: (____) _____ - _____

Email: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Cell Phone

Appointment Reminders: Home Phone / Cell Phone

Patient Portal Notifications: Text to Cell Phone / Email

FATHER: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No (IF NO, ADDRESS:_____)

Home Phone: (_____)_____-_____ Cell Phone: (____) _____- _____

Email: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Cell Phone

Appointment Reminders: Home Phone / Cell Phone

Patient Portal Notifications: Text to Cell Phone / Email

Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____

Insurance Carrier: _____ ID# _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____

Insurance Carrier: _____ ID# _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Authorized to bring in your child for medical treatment and as an emergency contact (other than parents)

Name & Relationship

1: _____ Relationship _____ Phone: (___) _____ - _____

2: _____ Relationship _____ Phone: (___) _____ - _____

3: _____ Relationship _____ Phone: (___) _____ - _____

Grello Pediatrics, PC

Patient Consent for Use and Disclosure of Protected Health Information

I have received a copy of Grello Pediatrics PC's Notice of Privacy Practices.

With my consent, Grello Pediatrics, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Grello Pediatrics, PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Grello Pediatrics, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at Grello Pediatrics, PC, 390 Montauk Hwy., West Islip, NY. 11795.

With my consent, Grello Pediatrics, PC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Grello Pediatrics, PC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Grello Pediatrics, PC may mail to my home or any designated school items that assist the school in its use of PHI to document legal absences, duration of refraining from certain activities, and placement in appropriate educational environments. In addition, with this consent, Grello Pediatrics, PC may discuss the same information above directly with the school. I have the right to request that GPPC restrict its use or disclosure of PHI to schools.

With my consent, Grello Pediatrics, PC may e-mail to me appointment reminder cards and patient statements. I have the right to request that Grello Pediatrics, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Grello Pediatrics, PC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Grello Pediatrics, PC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Grello Pediatrics, P.C.

Ciro T. Grello, M.D.,F.A.A.P
Christine Robles, D.O.
Catherine Melly, C.P.N.P.
390 Montauk Highway
West Islip, New York 11795
Phone: 631-422-0700 Fax: 631-422-0703

ASSIGNMENTS OF INSURANCE BENEFITS:
I hereby authorize direct payment of surgical/medical benefits to Grello Pediatrics P.C. for services rendered by doctor(s) in person or under doctor(s) supervision. I understand I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Grello Pediatrics P.C. to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefit.

Parent/Guardian Signature Date

Parent/Guardian (please print name)

NEWBORN INFORMATION
Newborns MUST be added to the policy immediately after birth. The Policy must be a FAMILY plan. After 30 days there is a risk of losing coverage for the baby if he/she has not been added to the policy. Primary Care Physician (PCP) - you need to name a PCP when you enroll the Newborn, change Doctors or change Insurance. This applies to insurance companies which require PCP's.

I acknowledge that I have been informed of the insurance requirements for enrollment.

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
I have received Grello Pediatrics P.C. notice of Privacy Practices.

Signature Print

Limitations Date