RESTON TOWN CENTER PEDIATRICS

Electronic Medical Record Update

Patient Name (Last) ______________________ (First) ______________________ (Middle) ______________________

Patient Date of Birth ______________________________

Primary e-mail address ______________________________

Preferred Pharmacy / Location ______________________________________

Other than parents/legal guardians, I authorize the following persons to bring, be seen & treated at RTCP (if any).

Name ______________	Name ______________	Name ______________
Relationship ______________	Relationship ______________	Relationship ______________
Telephone ______________	Telephone ______________	Telephone ______________

Race:

- o Caucasian
- o Asian
- o American Indian
- o Black or African American
- o Hispanic
- o American Indian or Alaska Native
- o Pacific Islander
- o Unreported / Refused to Respond

Patient Ethnicity:

- o Non-Hispanic
- o Hispanic

RTCP requests information on Ethnicity/Race to meet Federal Mandated Meaningful Use criteria

Preferred Language:

- o English
- o Spanish
- o Other ______________________________________

I have reviewed and understand my PATIENTS RIGHTS AND RESPONSIBILITIES. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its policy. I have received a copy of the RTCP NOTICE OF PRIVACY PRACTICES. It is posted in all patient waiting rooms, on our website, and is available upon request at any time.

Patients Signature (or responsible party) ______________________________ Date ______________