PEDIATRIC HEALTH CENTER

PATIENT INFORMATION (Child)

Last Name _____ Birth Hospital _____

Is this your first visit to our office? Yes / No

First Name _____ **Sibling Information**

Date of Birth_____ Name _____ DOB _____

Sex ❑ M ❑ F Name _____ DOB_____

Child's relationship to responsible party _____

RESPONSIBLE PARTY INFORMATION - WHERE PATIENT LIVES (All information must be completed)

Last Name _____ Choose preferred method of contact:

First Name _____ ❑ Home Phone ( ) _____

Address _____ ❑ Work Phone ( ) _____

City _____ State _____ ❑ Cell Phone/Text ( ) _____

Zip Code _____ Sex ❑ M ❑ F Relationship to Patient _____

Social Sec # _____ Email: _____

Date of Birth _____ Marital Status ❑ S ❑ M ❑ D ❑ W

❑ Employed ❑ Full-time Student ❑ Part-time Student Referred By X _____

Employer/School _____

INSURANCE INFORMATION (Policy Holder)/All information must be completed if insurance card is not available

PRIMARY INSURANCE

Policyholder's Name _____ DOB _____

Relationship to Patient _____

Insurance Name _____

S.S.# _____ Employer _____

Group Name or No._____

Insured's I.D. No. _____

Address of Policy Holder _____

SECONDARY INSURANCE

Policyholder's Name _____ DOB _____

Relationship to Patient _____

Insurance Name _____

S.S.# _____ Employer _____

Group Name or No._____

Insured's I.D. No. _____

Address of Policy Holder _____

EMERGENCY CONTACT:

Relationship to Patient _____ Home Phone ( ) _____

Name _____ Work Phone ( ) _____

Address _____ Cell Phone ( ) _____

City _____ State _____ Zip Code _____

Please Initial

AUTHORIZATION:

_____ I hereby consent to any necessary medical treatment for myself or the minor named above for whom I am legally responsible.

BILLING / PAYMENT:

_____ I permit payment directly to Doctors Office for any benefits due for services rendered. I understand that I am responsible for all charges; whether or not covered by my insurance company.

_____ Authorization is hereby granted for release of any information required to process insurance claims. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

NO SHOW POLICY:

_____ Patient must not arrive more than 15 minutes late; without proper notification

_____ Make sure to cancel wellness exam appointment a day prior to the appointment and sick appointments 1 hour prior to the appointment

_____ Patients with 3 (three) no-shows within 1 (one) year may be considered for dismissal from practice.

TEXT CONTACT CONSENT:

_____ I authorize Pediatric Health Center to contact me via text message (msg/data rates may apply) sent by an automatic system for appointment reminders or general health reminders or any other communication to better serve my needs. I understand that I can opt-out any time by contacting the practice.

Signature: _____ Date: _____

Pediatric Health Center

Care of Infants, Children, and Adolescents

❑ 11026 Vista Del Sol
El Paso, TX 79935
(915) 593-5444

Fax (915) 594-7147

❑ 3901 N. Mesa, St.
El Paso, TX 79902
(915) 838-0100

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Pediatric Health Center (PHC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

I have reviewed the Notice of Privacy Practices prior to signing this consent. PHC reserves the right to revise this Notice of Privacy at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PHC Privacy Officer at 11026 Vista Del Sol, El Paso, Texas 79935.

With this consent, PHC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. PHC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, as long as they are marked Personal and Confidential.

With this consent, PHC my e-mail to my home or other alternative location any items that assist the practice in carrying our TPO. I have the right to request that PHC 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 PHC's use and disclosure of my PHI to carry out TPO. I am also acknowledging that I have received PHC's Notice of Privacy Practices.

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, or later revoke it, PHC my decline to provide treatment to me.

_____ _____

Patient Name DOB

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print Name of Patient/Legal Guardian

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction, a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient, a state agency having legal custody of the child, a Texas school or child-care facility in which the child is enrolled, and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.

Parent, legal guardian, or managing conservator:

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Provider Statement

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com

Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Initial History Questionnaire

Form Completed By:	**Name:**		
Initial Date Completed:	ID Number:		
Date(s) Updated:	Birth Date:	Age:	Sex: M F

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Don't know Explain: _____

Does your child have any special health care needs? ☐ Yes ☐ No ☐ Don't know Explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Don't know Explain: _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Don't know Explain: _____

SOCIAL HISTORY

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? ☐ Yes ☐ No

If no, what is the child's current living situation?

☐ Single-parent custody ☐ Joint custody ☐ Adoptive family

☐ Other family members: _____ ☐ Foster care

How often does the child have visitation with parent(s) not living in the home?

_____

Instructions for health care professionals on how to use this form can be found in the *User Guide and Instructions for Toolkit Implementation* at https://toolkits.solutions.aap.org/bright-futures.

BIRTH HISTORY

Birth weight: _____

☐ Full-term ☐ Preterm _____ weeks ☐ Post-term _____ weeks

Delivery: ☐ Vaginal ☐ Cesarean ☐ Reason: _____

Any complications during birth or after birth? ☐ No ☐ Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

☐ No ☐ Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins?	☐ Yes	☐ No	☐ Unknown
Smoke or use e-cigarettes?	☐ Yes	☐ No	☐ Unknown
Drink alcohol?	☐ Yes	☐ No	☐ Unknown
Use marijuana?	☐ Yes	☐ No	☐ Unknown
Use illicit drugs?	☐ Yes	☐ No	☐ Unknown
Take other medications?	☐ Yes	☐ No	☐ Unknown

If yes, please list: _____

_____

Blood type:

Mother: _____ ☐ Unknown

Baby: _____ ☐ Unknown

Mother's lab results:

Hepatitis B	☐ Pos	☐ Neg	☐ Unknown
HIV	☐ Pos	☐ Neg	☐ Unknown
Group B streptococcus (GBS)	☐ Pos	☐ Neg	☐ Unknown

After birth, did the baby get:

Vitamin K shot?	☐ Yes	☐ No	☐ Unknown
Erythromycin eye ointment?	☐ Yes	☐ No	☐ Unknown
Hepatitis B shot?	☐ Yes	☐ No	☐ Unknown

How was the baby fed? ☐ Bottle formula ☐ Bottle breast milk

☐ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? ☐ Yes

☐ No Explain: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

The recommendations in this questionnaire do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

HE0564

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

Name: _____

PAST MEDICAL HISTORY (*continued*)

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

_____

_____

_____

_____

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

_____

_____

_____

_____

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
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Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				