Beaumont Pediatric Center, PLLC

3127 College Street Beaumont, TX 77701 (409) 899-1433 Fax (409) 981-9089

☐Dr. Hubbell ☐Dr. Brown ☐Dr. Worley ☐Dr. Roesler ☐Dr. Bartz ☐Misty Moss, FNP ☐Cheryl Smith, FNP

PATIENT INFORMATION SHEET

Please fill out all information below.

Patient

NAME:_____ DOB:_____ GENDER: M F

ADDRESS:_____ HOME PHONE:_____

CITY:_____ ST:_____ ZIP:_____ SSN:_____

Parents/Guardians

MOTHER:_____ FATHER:_____

DOB:_____ SSN:_____ DOB:_____ SSN:_____

ADDRESS:_____ ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____ CITY:_____ ST:_____ ZIP:_____

HOME PHONE:_____ HOME PHONE:_____

MOTHER EMPLOYER:_____ FATHER EMPLOYER:_____

MOTHER WORK #:_____ FATHER WORK #:_____

MOTHER CELL# _____ FATHER CELL #:_____

Drivers License #:_____ Drivers License #:_____

Emergency Contact – someone not living in the same household

NAME:_____ HOME PHONE:_____

ADDRESS:_____ RELATIONSHIP:_____

CITY:_____ ST:_____ ZIP:_____ CELL PHONE:_____

Information on Insurance Carrier other than parent (grand parent, step parent, etc.)

NAME:_____ DOB:_____

ADDRESS:_____ RELATIONSHIP:_____

CITY:_____ ST:_____ ZIP:_____ CELL PHONE:_____

Beaumont Pediatric Center, PLLC

Date:_____

Please list the first and last name of all siblings living in the household, date of birth and age.

Name	**Date of birth**	**Age**

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I am the parent of _____ by signing below I authorize the following people other than the biological mother and/or father, to bring my child to the providers at Beaumont Pediatric Center, PLLC for treatment. (please print name and relationship to patient)

Name	Relationship to Patient

I have received from Beaumont Pediatric Center, PLLC a copy of the company HIPPA Policy, Financial Policy and Office Policy. By signing below I understand my financial obligations to the practice as well as the Office Policy, HIPPA Policy, and obligations of the practice to protect my child's health information.

Messages may be left regarding my child at the following locations:

☐ Home Phone Ans. Machine ☐ Mothers Work ☐ Fathers Work

☐ Mothers Cell ☐ Fathers Cell ☐ _____

_____

Parents Signature Date

This information will stay on file at Beaumont Pediatric Center, PLLC and remain in effect unless requested to be changed by either parent.

Carl J. Hubbell, MD
T. Renee Brown-Nembhard, MD
Kyle E. Worley, MD
Misty Moss, FNP
Nathan Roesler, MD
Roger Bartz, MD
Cheryl Smith, FNP

Confidential Medical History Form for Children

Please bring this completed form to your child's office appointment

Name: _____ DOB: _____ Today's Date: _____

Birth History for Patient:

Was the pregnancy full term? Y or N
Were there complications with the pregnancy or delivery? Y or N
Did you go home in 24 - 48 hours? Y or N
If not why? _____
How much did your child weigh at birth? _____

Past Medical History: Has the child had any of the following Conditions?

- ☐ Abdominal problems?
- ☐ Any serious injury?
- ☐ Asthma?
- ☐ Behavior Problems?
- ☐ Broken Bones?
- ☐ Chronic Cough?
- ☐ Constipation?
- ☐ Sickle Cell
- ☐ Frequent Temper Tantrums?
- ☐ Hay fever/Sinus Problems?
- ☐ Hearing Problems?
- ☐ Heart Problems?
- ☐ Joint/Bone Problems?
- ☐ Kidney or Bladder infections?
- ☐ Many ear infections?
- ☐ Over Weight?
- ☐ Pneumonia?
- ☐ School Problems?
- ☐ Seasonal Allergies?
- ☐ Seizures?
- ☐ Skills are behind other kids?
- ☐ Underweight
- ☐ Vision Problem?
- ☐ Other? _____

Any Allergies to Medications? _____
Any Medications/Supplements taken frequently? _____

Social History:

Child has how many sisters? _____ Brothers? _____
Grade in school/Preschool _____
Usual Grades received? _____ (A,B,C's, Etc.)
Is your child in daycare/after school care? _____
Who lives in your home? _____

Exposures:

- ☐ Is there a smoker in the home/at babysitter's?
- ☐ Do you always use seatbelt or car seat in your vehicle?

Family History: Has any blood relative of your child had... (List Relative beside illness)

- ☐ Alcoholism?
- ☐ Allergies?
- ☐ Asthma?
- ☐ Bleeding Disorder?
- ☐ Blood Clots?
- ☐ Cancer?
- ☐ Deafness?
- ☐ Depression?
- ☐ Diabetes?
- ☐ Drug Addiction?
- ☐ Heart Problems?
- ☐ Heart Vessel Surgery?
- ☐ High Blood Pressure?
- ☐ High Cholesterol?
- ☐ Lung Disease?
- ☐ Mental Illness?
- ☐ Seizures?
- ☐ Strokes?
- ☐ Tuberculosis (TB)?
- ☐ Other conditions?
- ☐ Sickle Cell

Parents Signature: _____

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Authorization for Release of Information to Beaumont Pediatric Center, PLLC

PARENTS: You will need to send this form to your previous physician so they can send us your child's records

Section A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS:
I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____ **Date of Birth:**_____

The information requested will be provided by:
_____
_____
_____

Persons/Organizations receiving information:
Beaumont Pediatric Center, PLLC
3127 College Street
Beaumont, TX 77701

Section B: MUST BE COMPLETED FOR ALL AUTHORIZATIONS:
Please release the following information:

_x__Changing Physicians __x__ Office Notes __x__ Shot Record
__x__ Lab __x__ Hospital Records
____ Insurance Information ____ Billing Records

____ HIV information (please initial for release) ____ Mental Health Records (Please initial for release)

Only information generated by this office will be released.

Section D: MUST BE COMPLETED FOR ALL AUTHORIZATIONS:
Patient or Patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on ___/___/___ (mm/dd/yy) Initials:_____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation. Initials:_____

_____ _____
Signature of Patient or Patient's representative **Date**

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