Pediatric and Adolescent Medical Center

Name of patient: _____
Date of Birth (DOB):_____Gender: (Male / Female)
Social Security Number (SSN): _____
Address:_____
City:_____Zip Code: _____
Phone number: _____
Email: _____
Race:_____Ethnicity: _____

Emergency contact: _____
Relationship to patient: _____
_____
Phone number: _____

Person responsible for the patient: _____
Date of Birth (DOB):_____Gender: _____
Social Security Number (SSN): _____
Relationship to patient: _____
Address: _____

Name of insurance company: _____
Subscriber Name: _____
_____ Date of Birth (DOB):_____
Gender: _____
Social Security Number (SSN): _____
Subscriber Insurance ID: _____
Member ID: _____
Group Identification Number: _____
Pharmacy address: _____

PLEASE READ CAREFULLY AND SIGN AS INDICATED:
It is the sole responsibility of the parent / guardian to provide and maintain current contact information to the Pediatric and Adolescent Medical Center to ensure that contact can be made regarding their child. This includes, but is not limited to, current telephone numbers, postal address, and physical address. I understand and acknowledge that I am ultimately responsible for any fees incurred on my child regardless of insurance status. Fees must be paid in full at the time services are provided. The information provided above is true and correct.

Signature:_____Relationship:_____Date: _____

INITIAL HISTORY QUESTIONNAIRE

Completed by:_____Relationship with the patient:_____

General Information

Do you consider that your child is in good health? ☐No ☐Yes Explain: _____
Does your child have any special health care needs? ☐No ☐Yes Explain: _____
Has your child ever been hospitalized? ☐No ☐Yes Explain: _____

Social History

Please list everyone who lives in the child's home.

Name	Date of Birth / Age

Please list other siblings who do not live in the home.

Name	Date of Birth / Age	Where do they live?

Does the child live with both biological parents? ☐No ☐Yes
If not, what is the child's current situation? ☐ single parent custody ☐ shared custody ☐ adoptive family
☐ other family members:_____☐ foster care

How often does the child have visits with parents who do not live in the home?
_____

BIRTH HISTORY

Birth weight: _____

☐ full term ☐ premature:____weeks ☐post-term:_____weeks

Delivery: ☐vaginal ☐ cesarean ☐ reason: _____

Were there any complications during or after birth? ☐No ☐Yes

Explain: _____

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

☐ No ☐Yes Explain: _____

During pregnancy, the mother:

Take prenatal vitamins? ☐No ☐Yes ☐I don't know

Smoking or using e-cigarettes? ☐No ☐Yes ☐I don't know

Drink alcohol? ☐No ☐Yes ☐I don't know

Use marijuana? ☐No ☐Yes ☐I don't know

Using illicit drugs? ☐No ☐Yes ☐I don't know

Take other medications? ☐No ☐Yes ☐I don't know

If so, please list:

Blood group:

Mother:_____☐ I don't know Baby:_____☐ I don't know

Mother's lab results

Hepatitis B: ☐No ☐Yes ☐I don't know HIV: ☐No ☐Yes ☐I don't know

Group B Streptococcus (GBS): ☐No ☐Yes ☐I don’t know

After birth, the baby got:

Vitamin K Shot: ☐No ☐Yes ☐I don't know

An erythromycin eye ointment? ☐No ☐Yes ☐I don't know Hepatitis B injection? ☐No ☐Yes ☐I don't know

How was the baby fed? ☐ bottle formula ☐ breast milk bottle ☐ breastfed How long was the baby breastfed? _____

Did the baby go home to the birth mother from the hospital after the birth?

☐No ☐Yes Explain: _____

PAST HISTORY

Has your child had any of the following problems? DK = I don't know

Condition	Unsure	No	Yes	Details
Eye problems, cataracts or retinoblastoma?				
Visual impairment or concerns?				
Nasal allergies (dust, pets, or the environment)?				
Frequent ear infections?				
Hearing loss or concern				
Multiple cavities or tooth problems				
Frequent colds or sore throat				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Murmur or other heart problems				
High pressure				
Frequent stomach pain				
Constipation that needs medical treatment				
Food allergies or intolerance				
Being overweight or obese				
Urinary infection				
Kidney, ureter or bladder problems				
Bone, joint, or muscle problems				
Head or head trauma				
Seizures, convulsions, or neurological problems				

Other Medical Concerns:

SURGICAL HISTORY

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

Surgery / Procedure	Date of surgery / Child's age	Where	Details

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters had any of the following conditions?

Condition	Unsure	No	Yes	Details
Anemia or bleeding problems				
Asthma				
Allergies				
Alcohol problems				
Cancer (before age 55)				
Infant hearing loss				
Dental cavities or multiple cavities				
Depression or anxiety				
Developmental disability				
Diabetes				
Heart attack (myocardial infarction)				
Heart disease (before age 55)				
High blood pressure				
High cholesterol				
HIV or AIDS				
Kidney disease				
Liver disease				

Other Medical Concerns:

MEDICATION LIST

Name:	Date of Birth (MM/DD/YYYY):

Medication / Vaccine allergies or reactions:
Food / Environmental allergies or reactions:

Medications:

Name of Medication	Dosage	Frequency	Symptoms	Start Date	End Date

CONSENT TO TREAT A MINOR
The caregiver who is not a parent or guardian

In the case of my absence, I give permission to the following people to bring my child for their appointments and also to make decisions regarding necessary and/or routine treatment including, but not limited to exams, injections, immunizations and/or diagnostic procedures including X-rays or laboratory tests.

I have read all the information on this sheet and certify that the information I have provided is true and correct to the best of my knowledge.

_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)

Child's Name:_____ Date of Birth (DOB): _____

_____ _____
(Name of parent / guardian) (Relationship to patient)

_____ _____ _____
(Parent / Guardian Signature) (Phone) (Date)

MEDICAL INFORMATION RELEASE FORM
(HIPAA)

Name:_____ Date of Birth:_____/_____/ _____

Authorization for the Disclosure of Information

[ ] I authorize the release of information including diagnosis, records; examination that has been done to me and requests information. This information may be disclosed to:

[ ] The husband / wife _____
[ ] The child / children _____
[ ] Other _____

[ ] Information should not be released to anyone

This release of information will remain in effect until I complete it in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell phone: _____

If you can't contact me:

[ ] can leave a detailed message
[ ] please leave a message asking me to call you back
[ ] _____

_____

The best time to reach me is (day) _____ between (time) _____

Signature: _____

Date: _____/_____/_____

FINANCIAL RESPONSIBILITY / EXEMPTION FORM

Dear patient:

Confirmation of your coverage cannot always be done at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services rendered.

(Patient's name)	(Insurance company)
(Subscriber Name)	(Employer / Group)
(Permanent Address)	(Group Policy Number)
(City, State, Zip Code)	(Phone Number)

I have read the above and understand my possible financial responsibility for the services rendered and hereby adjust my signature as an acknowledgment of this understanding.

(Signature of patient)	(Date)

Vaccine Policy

Pediatric and Adolescent Medical center will follow the recommended vaccine schedule and guidelines established by the American Academy of Pediatrics (AAP) and the Center for Disease Control and Prevention (CDC), based on years of scientific study and data gathered. We strongly believe in the effectiveness of vaccines to prevent serious illness and to save lives and we believe in the safety of our vaccines. This vaccine schedule plays an important part in our responsibility to protect our communities and families from vaccine-preventable diseases.

Procedures and expectations for the vaccine guidelines are as follows:

- We highly encourage all patients and their respective caretakers to follow CDC, AAP, and Texas Department of Health vaccine schedules with vaccines starting at the age of 2 months.
- The Pediatric and Adolescent Medical center reserves the right to release/discharge patients from our practice who refuse to comply with AAP and CDC guidelines which dictate the vaccination list and schedule for children.

No-Show and Missed Appointment Policy

We at Pediatric and Adolescent Medical Center understand that you may need to cancel or reschedule a visit due to emergencies or other unforeseen issues. If you are unable to keep your appointment, please notify us at least 24 hours prior to your scheduled appointment time. To ensure that each patient is given the proper amount of time allotted for their visit and to enable us to provide the highest quality care to everyone, it's very important for each scheduled patient to attend their visit on time.

Please review the following policy:

- Please notify the Pediatric and Adolescent Medical Center at least 24 hours prior to your scheduled appointment should you need to change or cancel your reserved slot.
- If less than a 24-hour notice is given, the cancellation will be documented as a "No-Show/Missed" appointment.
- If you do not present to the clinic for your appointment at the designated time, this will be documented as a "No-Show/Missed" appointment.
- The Pediatric and Adolescent Medical center reserves the right to release/discharge patients from our practice who have neglected to show up to or have missed more than 3 appointments.

How to Cancel Your Appointment

To cancel appointments, please call the Pediatric and Adolescent Medical Center at (469)758-0232. If you do not reach us, please leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Child's Name: _____ Date of Birth (DOB): _____

_____ _____

(Name of parent / guardian) (Relationship to patient)

_____ _____ _____

(Parent / Guardian Signature) (Phone) (Date)