Pediatric Clinic, P.A.

Gerald A. Stagg, MD, FAAP
Joel D. Chapman, MD, FAAP
J. Colton Bradshaw, MD, FAAP
Marc E. Kimball, MD, FAAP
Michael D. Henry, MD, FAAP
Christopher E. Miller, DO, FAAP
Brandon J. Salgado, MD, FAAP

PATIENT

First | Middle | Last | Nickname (if any) | Present Age | Date of Birth

Mailing Address | Social Security # | ☐ Male ☐ Female | Primary Phone Number

Race: White Black / African American American Indian Asian Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Other or Undetermined

City / State /Zip

Preferred Language: English Spanish Other

PARENT/GUARDIAN

Mother's Name | Date of Birth | Primary Phone — Home Work Cell

Address (if different) | Social Security # | Driver's License# | Alternate Phone — Home Work Cell

Employer | Email Address

Father's Name | Date of Birth | Primary Phone — Home Work Cell

Address (if different) | Social Security # | Driver's License # | Alternate Phone — Home Work Cell

Employer | Email Address

Responsible Party (if parent under 18 years of age/Foster parent/Guardian) | Relationship | Date of Birth | Primary Phone — Home Work Cell

Address (if different) | Social Security # | Driver's License # | Alternate Phone — Home Work Cell

Employer | Email Address

INSURANCE

Patient's Primary Insurance Company | Name of Insured Party | Insured Date of Birth | Insured Phone

Insured Party Social Security # | Insured ID # | Policy Group # | Relationship to patient

Patient's Secondary Insurance Company | Name of Insured Party | Insured Date of Birth | Insured Phone

Insured Party Social Security # | Insured ID # | Policy Group # | Relationship to patient

EMERGENCY CONTACTS

Name — Phone

Name — Phone

Name — Phone

Name — Phone

SIBLINGS

Name — Date of Birth

Name — Date of Birth

Name — Date of Birth

Name — Date of Birth

Signature of Responsible Party Date

Update Signature Date

Update Signature Date

Update Signature Date

2001 N. Jefferson Medical Office Building, Suite 300 Mt. Pleasant, Texas 75455 903-572-9823 FAX 903-572-4812

Pediatric Clinic, P.A.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Printed Name of Patient

_____
Patient's Date of Birth

_____
Printed Name of Parent or Guardian

_____
Signature of Patient, Parent or Guardian

_____
Relationship to Patient

_____
Date

Pediatric Clinic, P.A.

PARENTAL CONSENT FOR TREATMENT

In accordance with Texas Law, the Pediatric Clinic will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent.

In Texas, a patient is considered a "minor" if he/she is under 18 years, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for the following child in my absence.

_____ _____

Patient/Child Patient/Child Date of Birth

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____

Parent/Legal Guardian Date

Pediatric Clinic, P.A.

PATIENT AUTHORIZATION

Patient/Child Name _____Date of Birth_____

Please initial all applicable boxes. If a category does not apply to you, please write "N/A".

Initials *MEDICAID ASSIGNMENT OF BENEFITS*

☐ I certify that the information I gave in applying for payment of Medicaid benefit is correct. I assign Medicaid benefits payable for Pediatric Clinic, P.A. services to the Pediatric Clinic, P.A.

FINANCIAL RESPONSIBILITY

☐ I will honor the Pediatric Clinic, P.A. payment policy by payment in full at the time services are rendered, unless prior arrangements have been made. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment for services rendered at the Pediatric Clinic, P.A. I am responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that I may be billed for out sourced services (i.e. lab, x-ray, etc.); and I may receive additional billing from another facility. I agree to pay all expenses related to collection, whether by collection agency or by an attorney.

INSURANCE RESPONSIBILITY

☐ I irrevocably assign and transfer to the Pediatric Clinic, P.A. all insurance benefits covering the Pediatric Clinic, P.A. services for the payment of serviced rendered. I understand it is my responsibility for providing a current copy of my insurance card and to comply with all pre-certification requirements.

AUTHORIZATION FOR CARE

☐ I grant permission for the Pediatric Clinic, P.A. to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ I hereby authorize the Pediatric Clinic, P.A. to release necessary information for the following reasons: to other physicians for continuing professional care; to any insurance company or their representatives; or otherwise as allowed by law. I release the Pediatric Clinic, P.A. from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time.

_____ _____

Signature of Parent/Legal Guardian Date

Pediatric Clinic, P.A.

NEW PATIENT

To Be Completed By Parent:

Name _____ Birth Date _____ Date First Seen _____
Race _____ Sex _____ Insurance _____
Hospital born _____ Address _____
Obstetrician _____ Address _____
Referred by _____
Father's Name _____ Address _____
Mother's Name _____ Address _____

To Be Completed By Nurse: Family History

ALLERGIES

	Age	Health	Food/Enviro.	Type of Allergy
Mother				
Father				
Sibling				
Sibling				

OTHER

Tuberculosis _____ TBC Contacts_____
Diabetes_____ Convulsive Disease_____
Mother's Blood Type _____RH_____
Baby's Blood Type _____

Birth and Development

Term _____ Delivery _____ Birth Weight _____
Condition at Birth _____ Apgar Score _____
Cyanosis _____Jaundice _____

Feeding History

Breast _____ Formula _____ Vitamins _____

Pediatric Clinic, P.A.

Please circle each item that applies to your child:

FAMILY HISTORY Is there family history of any of the following:

- •ADHD
- •Alcoholism
- •Anemia
- •Arthritis
- •Asthma
- •Bleeding disorder
- •Breast cancer
- •Cervical cancer
- •Congenital heart disease
- •Colon cancer
- •Colon polyps
- •Coronary artery disease
- •Depression
- •Diabetes
- •Heart disease
- •Hepatitis B
- •Hepatitis C
- •Hypertension
- •Hyperlipidemia
- •Kidney disease
- •Learning disability
- •Lung cancer
- •Meanoma
- •Migraine
- •Ovarian cancer
- •Pancreatic cancer
- •Parental allergies:_____
- •Seizures
- •Skin cancer
- •Suicide
- •Tuberculosis
- •Thyroid disease

SOCIAL HISTORY Do any of the following affect your child:

- •History of domestic abuse
- •Religion affecting care
- •Foster care
- •Parents divorced
- •Lives with grandparents
- •Adopted
- •Passive smoke – Yes / No
  If yes, explain_____
  _____

PAST MEDICAL HISTORY Has your child ever been diagnosed with any of the following:

- •ADD
- •ADHD
- •Anemia
- •Apnea
- •Appendicitis
- •Asthma
- •Diabetes
- •Esotropia
- •Exotropia
- •Febrile seizures
- •Fracture
  type_____
- •GERD
- •Head injury
- •Hepatitis B / C
- •Hypertension
- •Inguinal hernia
- •Motor vehicle accident
- •Recurrent otitis media
- •RSV
- •Umbilical hernia
- •Urinary tract infection

PAST SURGICAL HISTORY Has your child had any of the following surgeries:

- •Abdominal surgery
- •Adenoidectomy
- •Appendectomy
- •Back surgery
- •Bronchoscopy
- •Cholecystectomy
- •Circumcision
- •Extra digits
- •Hernia-umbilical
- •Hernia-inguinal
- •Knee arthroscopy
- •Myringotomy
- •Post-op delirium
- •Probed tear duct
- •Tonsillectomy
- •Tonsillectomy & adenoidectomy
- •Anesthesia problem – Yes / No
  If yes, explain_____
  _____
- •Surgical complications – Yes / No
  If yes, explain_____
  _____

_____ _____

Parent/Legal Guardian Signature Date