Texas Family Pediatric Group P.A.

Patient Information

Patient Registration **Today's Date:_____**

Patient's First Name:_____Last Name:_____Middle Initial:_____

Date of Birth:_____Sex:_____Race:_____

Address:_____

City:_____State:_____Zip:_____

Mother's Name:_____Date of Birth_____

Address:_____City_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work phone:_____

Employer/Occupation:_____SSN:_____-_____-_____

Father's Name:_____Date of Birth_____

Address:_____City_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work phone:_____

Employer/Occupation:_____SSN:_____-_____-_____

Emergency Contact:_____Phone:_____

Relationship to child:_____

In the event the above information changes and our system is not updated, this person would know how to contact you.

Please bring a copy of your child's insurance card to all visits.

Please List all insurances Patient is covered under.In order for us to file your insurance correctly, please complete the following:

Primary Insurance Name:_____Type of Product: Medicaid,HMO,POS,PPO

PolicyID:_____Group#_____Phone#_____

Insured's Name: _____Date of Birth: _____SS#_____

Secondary Insurance Name: _____ Type of Product: Medicaid,HMO,POS,PPO

PolicyID:_____Group#_____Phone#_____

Insured's Name:_____Date of Birth:_____SS#_____

Does the patient have Medicaid and Private Insurance?____YES /NO (Please circle one)

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Patient History

Name:_____D/O/B_____M/F_____

Birth History

Hospital_____Location_____

Type of delivery: Vaginal C-Section Forceps Mother's Age:_____ Born at _____weeks

Birth Weight:_____LBS_____OZ Length:_____

Did the baby have any trouble while in the hospital? Jaundice____Infection____Breathing_____Other___

ILLNESS HISTORY(Y/N)

EYE PROBLEMS ____
ASTHMA ____
CHICKEN POX _____
PNEUMONIA _____
EAR INFECTIONS ____
HEART MURMUR ____
HEART PROBLEMS ____
ECZEMA ____
ANEMIC ____
SEIZURES ____
CONSTIPTION ____
URINARY TRACT INFECTION ____
TEETH PROBLEMS ____
ALLERGIES ____
NERVOUS SYSTEM ____
HOSPITALIZATIONS ____
OPERATIONS/SURGERIES ____

FAMILY MEDICAL HISTORY

Disease	Yes/No	Relationship
Aids		
Allergies/Eczema		
Anemia/Blood Disorder		
Asthma/Resp Problems		
Cancer		
Cholesterol		
Depression		
Diabetes		
Drug/Alcohol Problems		
Epilepsy		
Heart attack before 50		
Heart disease		
High blood pressure		
Migraine		
Sudden Infant Death		
Tuberculosis		

ALLERGIES (Please List)

Medications:_____**Foods:**_____**Other**:_____

FAMILY PROFILE:

Father's Name:_____DOB:_____ Occupation:_____

Mother's Name:_____DOB:_____ Occupation:_____

Sibling Name:_____DOB:_____Sex:_____M/F_____

Sibling Name:_____DOB:_____Sex:_____M/F_____

Sibling Name:_____DOB:_____Sex:_____M/F_____

Sibling Name:_____DOB:_____Sex:_____M/F_____

Who Lives in the house with the Child?_____

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Authorization to Treat

I the parent/guardian of _____, Hereby Authorize Texas Family Pediatric Group to provide medical treatment and diagnostic tests believed necessary for the this child.

Signature:_____Date:_____

Please list the people whose permission you grant to authorize treatment and seek information (when you not available to give consent) pertaining to the care of your child.

Name_____Phone_____Relationship to child_____

Name_____Phone_____Realtionship to child_____

Name_____Phone_____Realtionship to child_____

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that Texas Family Pediatric Group provided me with the Notice of Privacy Practices. I give permission for my protected health information to be used by Texas Family Pediatric Group and disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice. I understand that I may request restrictions on the use or disclosure of my protected health information and that if Texas Family Pediatric Group agrees to this request, the restriction will be binding on the practice. I further understand that I may revoke, in writing this consent to use and disclose protected health information.

_____ _____

Patient's Name Patient's Representative

_____ _____ _____

Relationship to Patient Representatives Signature Date

Guarantor's Statement of Responsibility

1. That the responsible party will make immediate payment for services rendered; If Texas Family Pediatric Group is contracted with your insurance company, payment is due immediately on co-pays, non-covered services and co-insurance.
2. That it is the responsibility of the policy holder to familiarize themselves with their insurance policy, and its benefits and limitations.
3. That I authorize payment of medical benefits to Texas Family Pediatric Group for services rendered. I also understand that ultimately I am financially responsible to Texas Family Pediatric Group for all charges whether or not covered by my insurance carrier.

Responsible Party Signature:_____Date:_____
Print Name of Responsible Party:_____Relationship to Patient:_____