NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

Please list all those living in the patient's home:

Name	Relationship to patient	DOB

Does the patient live with both biological parents? _____
If not, what is the custody agreement? _____

MEDICAL HISTORY

Were there any issues with the pregnancy or delivery with this patient?

_____

_____

Did the baby go home from the hospital when their mother did after birth? _____

Has the patient had any surgeries? Please list.

_____

_____

_____

Has the patient ever been hospitalized overnight? Please explain.

_____

_____

PATIENT NAME _____ DOB _____

Please circle and explain if the patient has had any of the following:

Eye or vision problems

Allergies

Arthritis or rheumatologic problems

Frequent ear infections

Hearing loss

Asthma or wheezing

Pneumonia

Heart issues or murmurs

High blood pressure

Constipation

Bladder or kidney infections

Bone or joint problems

Concussion or head injury

Seizures

Skin issues

Thyroid or other endocrine problems

Diabetes

Genetic disorder

Anemia

Bleeding issues

Cancer

Bone marrow or organ transplant

HIV

Developmental delays

School problems or learning difficulties

Anxiety or depression

PATIENT NAME _____ **DOB** _____

FAMILY HISTORY (Please include patient's parents, grandparents, siblings, aunts and uncles. DO NOT include great grandparents or great aunts and uncles).

Circle and explain any that apply. Please note who had the issue.

Anemia

Arthritis or rheumatologic problems

Bleeding issues

Asthma

Allergies

Cancer

Childhood hearing loss

Depression

Anxiety

Developmental disability

Diabetes

Heart disease

High blood pressure

High cholesterol

HIV

Kidney disease

Liver disease

Mental health conditions

Seizures

Stroke

Substance abuse

Thyroid or endocrine disease

Tuberculosis

Vision or eye problems

POOLE PEDIATRICS, P.A.
******* PATIENT INFORMATON (Page 1 of 2) *******

Last Name _____ **First Name** _____ **Middle Name** _____ **Sex** ____ **DOB** _____

Last Name _____ **First Name** _____ **Middle Name** _____ **Sex** ____ **DOB** _____

Last Name _____ **First Name** _____ **Middle Name** _____ **Sex** ____ **DOB** _____

Last Name _____ **First Name** _____ **Middle Name** _____ **Sex** ____ **DOB** _____

Address: _____ **City**: _____ **State**: _____ **Zip code**: _____

Ethnicity (Please select all that apply):

African American _____ Asian _____ Caucasian _____ Hispanic/Latino _____ Native American _____ Pacific Islander ___ Other ____

PARENT/GUARDIAN INFORMATION

Father/Legal Guardian's Last Name: _____ **First Name**: _____

DOB: _____ SS **#** _____-____-_____ Marital **Status**: Single _____ Married _____ Separated _____ Divorced _____

Address: _____ **City**: _____ **State**: _____ **Zip code**: _____

PREFERRED CONTACT PHONE NUMBER (PLEASE CIRCLE ONE): HOME CELL WORK

Home Phone: _____ **Cell**: _____ **Work:** _____

Email: _____

Occupation: _____ **Employer**: _____

Mother/Legal Guardian's Last Name: _____ **First Name:** _____

Mother's Maiden Name: _____

DOB: _____ SS **#**_____-____-_____ Marital **Status**: Single _____ Married _____ Separated _____ Divorced _____

Address: _____ **City**: _____ **State**: _____ **Zip code**: _____

PREFERRED CONTACT PHONE NUMBER (PLEASE CIRCLE ONE): HOME CELL WORK

Home Phone: _____ **Cell**: _____ **Work:** _____

Email: _____

Occupation: _____ **Employer**: _____

Preferred Pharmacy – Electronic Prescribing Enrollment

Pharmacy Name: _____ **Phone:** _____

Address: _____ **City**: _____ **State**: _____ **Zip code**: _____

INSURANCE INFORMATION: **It is your responsibility to provide our office with any changes in insurance policy information. **

Insurance Company: _____ **Employer's Name**: _____

Primary Insured's Name: _____ **DOB**: _____ **Relationship**: _____

POOLE PEDIATRICS, P.A.
******* PATIENT INFORMATON (PAGE 2 of 2) *******

ASSIGNMENT OF BENEFITS AND CONSENT TO TREAT

I hereby authorize the release of any medical information necessary to process an insurance claim and assign payment to be made to Poole Pediatrics, P.A. **I understand that I am financially responsible for any fees incurred regardless of the status of my insurance claims. This includes fees for medical services not covered by insurance.** As parent/guardian of the above patient, I consent to treatment of said patient. A photocopy of this assignment is to be considered as valid as the original.

Signed: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Poole Pediatrics, P.A.

NOTICE OF PRIVACY PRACTICES (Page 1 of 2)

This notice describes how medical information about your child may be used and disclosed and how you can obtain access to this information. Please review it carefully.

With my authorization, Poole Pediatrics, P.A. or staff thereof may use and disclose protected health information (PHI) about me or my child to carry out treatment, payment and healthcare operations (TPO). Please refer to our Privacy Policy for a more complete description of such uses and disclosures. A copy is located in our waiting room. I have a right to review the Privacy Policy prior to signing this authorization. Our practice reserves the right to revise its Privacy Policy at any time. A revised Privacy Policy may be obtained by forwarding a written request to our Privacy Officer at this office address. With my authorization, Poole Pediatrics, P.A. or staff thereof may fax PHI or call my home or other designated location and leave a message on voice mail 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 child's clinical care, including but not limited to non-critical or case sensitive laboratory results. Although every effort will be made to get this information to the correct person, there may be circumstances where PHI is misdirected due to misdialing or incorrect fax numbers. We are not liable in these instances. With my authorization, Poole Pediatrics, P.A. or staff thereof may mail to my home or other designated location any items that assist the practice in carrying out TPO. I have the right to request that Poole Pediatrics, P.A. or staff thereof restrict how it uses or discloses my PHI to carry out TPO. 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 authorizing Poole Pediatrics, P.A. or staff thereof to use and disclose TPO. I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Poole Pediatrics, P. A. or staff may decline to provide treatment to my child.

I understand that under the HIPAA Act of 1996, I have certain rights to privacy regarding PHI. I understand that this information can and will be used to (1) conduct, plan, and direct my child's treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, (2) obtain payment from third-party payers, and (3) conduct normal healthcare operations such as quality assessment and physician certifications. I have read and understand this Notice of Privacy Practices and may request a copy containing a more complete description of the uses and disclosures of my health information. I understand it may be changed at any time and that I can receive a copy upon request. You have a right to receive confidential communications of your child's PHI. You may also request an accounting of disclosures of your PHI from this office. I understand that this office will provide this information within 30 days from receipt of written request and that a fee for this may be charged. I understand that I may register a complaint with this office if I suspect that my privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. You may speak with our office manager to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practice is effective as of May 11, 2026.

Text/Voice/Automated Messaging: I authorize Children's Health Mobile Messaging to send communications by text message, voice and automated calls to the cell phone number I provide.

I acknowledge that message and standard data rates and fees will apply, message frequency rates may vary, full security is not guaranteed over telephone networks, and I will need to protect my phone with a password or PIN to prevent unauthorized access. I understand that I may not use text and automated messaging to provide notification of the patient's healthcare needs. Children's Health Mobile Messaging privacy policy and SMS terms of service are available at childrens.com/footer/policies-procedures. Text HELP to 77444 for mobile messaging assistance, or text stop to 77444 to opt out of Children's Health Mobile Messaging.

Note: Recipients of text, voice and/or automated messaging may opt-out at any time. Reminders are included of how to opt out upon initial text and annually thereafter.

Poole Pediatrics, P.A.

NOTICE OF PRIVACY PRACTICES (Page 2 of 2)

PLEASE LIST THE FIRST AND LAST NAMES OF ANYONE WHO MAY BRING YOUR CHILD TO SEEK TREATMENT OR RECEIVE PHI:

1._____ 2. _____

3._____ 4. _____

Patient's Last Name_____ First Name_____

Patient's Last Name_____ First Name_____

Patient's Last Name_____ First Name_____

Patient's Last Name_____ First Name_____

Parent's/Legal Guardian's Printed Name_____ Date_____

Parent's/Legal Guardian's Signature_____

POOLE PEDIATRICS, P.A. FINANCIAL POLICY (Page 1 of 2)

We at Poole Pediatrics, P.A. are committed to providing you with the highest quality of care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

You are personally responsible for payment at the time of service for all charges that result from care provided by Poole Pediatrics, P.A., including any amounts not covered by your health plan. To assist us in establishing your Poole Pediatrics, P.A. financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information, and demographic information.
- Satisfy all insurance co-payments, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and Poole Pediatrics, P.A. with any additional information requested to complete the processing of claims filed on your behalf.

You are responsible for filing secondary insurance claims.
A returned check fee of $30 will be charged for any checks that are returned unpaid.
Delinquent accounts will be turned over to a collection agency.

UNACCOMPANIED MINORS: Minors must have an authorization for medical treatment signed by their parent/guardian. The minor is responsible for providing current insurance information at the time of the visit. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE: Poole Pediatrics, P.A. does not get involved in disputes between divorced parents regarding financial responsibility for their child(ren)'s medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse. Please note that co-payments and/or deductibles are expected at the time of service regardless of who brings the patient(s) in.

REGARDING HEALTH PLANS AND INSURANCE: For each visit to Poole Pediatrics, P.A., it is your responsibility to make sure Poole Pediatrics, P.A. is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. If we are not contracted with your health plan, we will require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your health plan. Should your health plan require a more detailed description of services, please have them request it in writing. If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician to obtain an insurance referral. It is your responsibility to obtain a referral before being seen by a specialist. If a referral is not obtained in advance; you may be held responsible for payment in full to the specialist.

ASSIGNMENT OF BENEFITS: I, the undersigned, authorize payment of medical benefits to Poole Pediatrics, P.A. for any services furnished to my child(ren) by the practice. I also authorize you to release to my child(ren)'s insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child(ren). This information will be use to evaluate and administer claims of benefits. This assignment shall remain valid until written notice is given by me.

RELEASE OF INFORMATION: You attest to the following: I agree to the release of any and all medical information and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity for an indefinite period or until I submit a written

revocation of this release. This consent to release and obtain information is valid until revoked and I may revoke this consent in writing at any time, except with regard to disclosures already made.

Date: _____

Guarantor Signature_____ Print Name_____

Relationship to Patient_____ Patient Name_____

POOLE PEDIATRICS, P.A.

Julie D. Poole, M.D., FAAP
3601 North Star Road
Richardson, Texas 75082
Phone (214) 343-0818 Fax (214) 343-3410

OFFICE POLICY ACKNOWLEDGMENT

Please review and acknowledge the following office policies:

Late Arrivals
Patients who arrive more than 10 minutes late may be seen at the next available appointment time or may be asked to reschedule. Patients who arrive on time will be given priority. If you anticipate arriving late, please contact the office as soon as possible to determine whether a later appointment time is available.

Missed Appointments & Cancellations
Our doctors and staff strive to be available to meet the needs of all patients. When a patient does not arrive for a scheduled appointment, another patient loses the opportunity to be seen. Appointments that are not canceled at least 24 hours in advance, as well as no-show appointments, will be subject to a $50.00 fee. This policy is effective December 2024.

Appointment Reminders
Appointment reminder calls are provided as a courtesy. It is the responsibility of the parent or guardian to remember and keep all scheduled appointments.

Copy of Medical Records: There is a fee for copying medical records which will be charged based on the size of the chart. This is regardless of what the copies are for. There is a two-week turnaround for this request.

By signing below, I acknowledge that I have read, understand, and agree to comply with the appointment policies outlined above.

Date: _____

Patient Name: _____

Parent/Guardian Name: _____

Signature: _____