FULL CARE PEDIATRICS

PATIENT INFROMATION:

Name: (Last) ______________________ (First) ______________________ (M.I.) _____

Street Address: ______________________ (Apt #) __________

City: ______________ State: ________ Zip Code: ______________

Home Phone: ______________ Cell Phone: ______________

Date of Birth: ______________ Sex: F / M

Preferred Language: ____________ Race: ____________ Ethnicity: ____________

Email: ______________________________

PARENTS/GUARDIAN INFORMATION

Father's/Guardian Name: ______________________ DOB: __________ SS#: ______________

Employer: ______________ Work Phone: ______________ Home Phone: ______________

Mother's/Guardian Name: ______________________ DOB: __________ SS#: ______________

Employer: ______________ Work Phone: ______________ Home Phone: ______________

Religion: ______________

Parent's Relationship: Married Separated Divorced Living Together

Guardian's Relationship: Grandparent Aunt/Uncle Foster Other: __________

INSURNACE SUBSCRIBER

Policy Holder Name: ______________________ DOB: ______________ Sex: M/F

SS#: ______________ Relationship to patient: ______________

Address: ______________ Home phone: ______________

City: ______________ State: ______________ Zip Code: ______________

Employer: ______________ Work Phone: ______________

I hereby authorize direct payment of medical benefits to Full Care Pediatrics for service. I understand that I 'am financially responsible to any balance not covered by my insurance.I hereby authorize Full Care Pediatrics to release my medical or incidental information that may be necessary for either medical or in processing applications for financial benefit.

Patient Name: ______________________ Date: ______________

Parent Name: ______________________ Signature: ______________

FULL CARE
PEDIATRICS

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Full Care Pediatrics may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Full Care Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Full Care Pediatrics reserves the right to revise its Notice of Privacy practices at any time.

With my consent Full Care Pediatrics may **CALL** my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Full Care Pediatrics may MAIL to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Full Care Pediatrics may **E-MAIL** me appointment reminders and patient statements. I have the right to request that Full Care Pediatrics restrict how it uses or discloses my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Full Care Pediatrics use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____

Patient Name

____

Printed Name of Parent/Legal Guardian

______________________________ ______________

Signature of Parent/Legal Guardian Date

FULL CARE PEDIATRICS

Request of Release of Patient Medical Records

Patient Name:______________________________________ DOB:_____________

Parent's Signature:______________________________Offcie Staff:______________________________

I hereby authorize records from:

Name:____

Address:____

City/State/Zip:____

Phone:__________________________Fax:________________

I hereby authorize records to:

Full Care Pediatrics

6750 Tezel Rd. Ste # 103

San Antonio, Texas 78250

P:210-680-0800

F:210-680-0844

For the purpose of review of medical history by current treating physician.

I understand that authorizing the disclosure of this health information is voluntary. I have the right to refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my child's health information, I can contact t the authorized individual or organization making disclosure.

I understand that the information in my child's medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my child's policy.

I have read the information provided on this release form and do hereby acknowledge that I 'am familiar with and fully understand the terms and conditions of this authorization.

____ ____________

Signature of Patient/Parent/Guardian or Authorized Representative Date

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name | Child's Middle Name

__/__/____ ****Children under 18 years only.*** Child's Gender: ☐ Male ☐ Female

Child's Date of Birth

Child's Address | Apartment # | Telephone

City | State | Zip Code | County

Mother's First Name | Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: ______________________
Printed Name

______________ ______________________
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and **affirm** that consent has been granted. **DO NOT fax to ImmTrac. Retain this form in your client's record.

FULL CARE PEDIATRICS

NEW PATIENT MEDICAL HISTORY INTAKE FORM BIRTH HISTORY:

Child's name: Date of birth:

Born at: Gestational age: ( ) full term ( ) weeks

Delivery: ( ) natural ( ) forceps assist

( ) vacuum assist ( ) induced

( ) spontaneous ( ) C-section

Birth Weight: Discharge weight:

PREGNANCY HISTORY

Pregnancy complications ( ) yes ( ) no ______________________________

High blood pressure ( ) yes ( ) no ______________________________

Gestational diabetes ( ) yes ( ) no ______________________________

Tobacco use ( ) yes ( ) no ______________________________

Alcohol use ( ) yes ( ) no ______________________________

Other drugs ( ) yes ( ) no ______________________________

Birth complications ( ) yes ( ) ______________________________

PAST MEDICAL HISTORY:

Prior hospitalizations: ( ) yes ( ) ______________________________

Prior surgeries: ( ) yes ( ) no ______________________________

Allergies: ______________________________

Please list any medical issues or chronic illness that your child has:

____

____

FAMILY HISTORY:

Please indicate if there is a family member with any of the following conditions:

FULL CARE PEDIATRICS

Condition: Family member(s) affected:

Asthma ( ) yes ( ) no ________________

Heart disease ( ) yes ( ) no ________________

Heart attack ( ) yes ( ) no ________________

Diabetes ( ) yes ( ) no ________________

Seizures ( ) yes ( ) no ________________

Blood disorders ( ) yes ( ) no ________________

High blood pressure ( ) yes ( ) no ________________

Mental illness ( ) yes ( ) no ________________

Cancer ( ) yes ( ) no ________________

Kidney disease ( ) yes ( ) no ________________

Other disease(s) ( ) yes ( ) no Comments: