**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Patient Information** | | |
| First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sex at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_  Primary Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. #\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Parent/Guardian Information** | | |
| Parent/Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_  Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Parent/Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_  Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Emergency Contact** | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ | | |
| **Insurance Information** | | |
| **Primary Insurance**  Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_  Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policyholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy holder DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  Policyholder SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Secondary Insurance**  Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_  Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policyholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policyholder DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  Policyholder SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**CONSENT TO TREAT** – **Please read carefully**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR TREATMENT**

I hereby authorized evaluation and treatment by the physicians and staff associated with

Temple Pediatrics, PLLC. I understand and agree that the signatures and dates on this form will

not expire without written notice or in the case that a minor becomes the age of 18, and that

a photocopy of this form is considered valid as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

In my absence, I hereby give authorization for the person(s) listed below to bring my child to Temple Pediatrics, PLLC and to consent for any and all recommended medical services.

Please note: All minor children (anyone under the age of 18) must be accompanied by a parent, legal guardian, or authorized adult listed above. **No exceptions.**

\*This authorization will remain in effect until changes are made by the parent/guardian

Authorized person(s)/Relationship to child (must be 18 years of age or older):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name/Relationship)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**CONSENT TO USE** & **DISCLOSE HEALTH INFORMATION**

***Patients 18 Years and Older***

*This office is required by federal regulations to inform our patients in regards to the use of their health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA*

I understand that as part of my healthcare, Temple Pediatrics, PLLC originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatment.

**I understand that as of my 18th birthday, I am considered an adult. Therefore, I need to give written consent to discuss my medical information with anyone, other than myself, including my parents.**

I understand that it is my responsibility to inform Temple Pediatrics, PLLC in writing of any changes pertaining to this release.

By signing this form, I hereby authorize Temple Pediatrics, PLLC to discuss with and release medical information to my parent/guardian(s) as previously listed. This release is written without restriction and includes information related to mental health.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Phone Number of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Temple Pediatrics, PLLC FINANCIAL POLICY– Please Read Carefully—-----DONE**

\*Thank you for trusting Temple Pediatrics, PLLC to partner in your health care. This financial policy should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided.

\*Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

\*Copayment, deductible or coinsurance is due at the time of service. Any balances that are applied to your deductible must be paid before the next office visit. **All balances must be paid in full at the time of the service.**

\*You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of service. Patient due balances noted on your monthly statement are due within **30 days** of receipt. Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent. New patients without insurance, or if insurance coverage cannot be verified, are required to pay at the time of service. *We offer a cash rate. Please contact our office for more information about cash rates.*

\*Billing statements are sent out each month. Any balance not covered by your insurance must be paid in full before the next appointment. Unpaid balances over 90 days may be referred to a collection agency, which may affect your credit. *If your account is referred to an outside collection agency, there will be a* ***fee of 30%*** *which will be applied at the time of referral. Non-sufficient fund (NSF) checks will result in a* ***$25 processing fee****.*

\*We understand that financial circumstances vary from patient to patient. If you are unable to pay your balance in full, you must call our business office at (555) 555-5555 to make payment arrangements.

\****24 hour prior notice of appointment cancellation is required***. A **$25.00** cancellation fee will apply after the second cancellation that does not meet our requirements. A **$50.00** cancellation fee will apply after the third cancellation that does not meet our requirements.

\***A $25.00 charge** for *printed* medical records must be paid at the time the records are requested.

\*There will be a charge for after hours calls. The charge will be **$25.00 billed directly to the** **patient**. This fee is *not* covered by any insurance plan.

\* **We accept Cash or Credit/Debit cards. Please note:** **We DO NOT accept checks.**

I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay the additional 30% fee.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**INSURANCE AUTHORIZATION – Please read carefully**

* As a courtesy to our patients we have enrolled in many managed care programs. However, we do

not take responsibility for items that are not covered by your individual plan.

* We will not file any claims for patients without an insurance card. You can request your

insurance company to fax or provide you with insurance documentation of coverage that includes

all billing information.

* We will not be responsible for any denied claims due to filing deadlines if new insurance

is not presented to us at the time of service.

* Prior to the office appointment, please be sure that you have contacted your insurance company to

add your new baby/child to the insurance policy. If the claim is denied, you will be responsible

for payment.

* It is advised that all patients verify (if not already known) to see if we are a network provider for

your insurance.

* Check which lab your insurance company is contracted with.
* Our clinic holds an additional stock of state mandated immunizations available for your child free

of charge if you meet the criteria of being underinsured. A **$14.00** charge per vaccine

administration will apply.

**AUTHORIZATION**

As a courtesy, Temple Pediatrics, LLC will verify and file insurance, but the practice cannot

guarantee payment. I understand that I am financially responsible for services rendered as and when

charges are incurred. I hereby authorize Temple Pediatrics, PLLC and/or the rendering physicians(s)

to release all medical information required by my insurance company to file claims for medical

benefits. I authorize payment of all applicable benefits directly to Temple Pediatrics, PLLC. This

authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as

valid as the original. Consent to release information acquired in the course of examination and/or

treatment in regards to treatment, payment of services and operations is understood and explained to

me in the posted Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

It excludes disclosures we may have made to you if you authorized us to make the

disclosure, for a facility directory, to family members or friends involved in your care,

or for notification purposes, for national security or intelligence, to law enforcement

(as provided in the privacy rule) or correctional facilities, as part of a limited data set

disclosure. You have the right to receive specific information regarding these

disclosures that occur after April 14, 2003. The right to receive this information is

subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us**, upon request, even

if you have agreed to accept this notice electronically.

**3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe

your privacy rights have been violated by us. You may file a complaint with us by notifying

our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Samantha Harmon, PNP at (555) 555-5555 or admin@templepediatrics.com for further information about the complaint process.

This notice was published and becomes effective on March 2, 2024. If you wish to have a

copy of this document for your records, please ask the front desk staff to print you a copy.

You may also download a PDF version of this document from our web site:

www.templepediatrics.com

**I hereby acknowledge the receipt of “Temple Pediatrics, LLC Notice of Privacy Practices, Version I” and agree to the terms and conditions stated in this document:**

*This is only the last page of the Notice of Privacy Practices. If you would like to have a copy of all pages, please let us know or visit our website.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**WELLNESS VISIT NOTICE**

Thank you for trusting our practice with your child’s health care. We want to provide the most comprehensive care for all your visits and need to make you aware of certain billing requirements set by the American Medical Association (AMA).

AMA describes a wellness exam as follows: *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures.*

If you present at your wellness exam with symptoms of an illness the provider will treat you for the illness and the wellness exam will need to be rescheduled as AMA does not allow for an emergent sick visit and wellness visit on the same day.

If, at the time of the wellness visit, the provider reviews any pre-existing condition that triggers a referral, prescription (even if not picked up), lab work or radiology then your insurance carrier will be billed for **BOTH** the wellness visit and the sick office visit. You will be responsible for any expense incurred for this visit, be it a copay, coinsurance or deductible.

Please do not call our office requesting we waive the additional cost as our provider(s) is responsible for documenting all medical information gathered at the time of the visit, regardless of who brought up these conditions, and billed to your insurance carrier as required by AMA guidelines.

Thank you for your patronage.

I hereby attest that I have received these instructions and understand this billing policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**PATIENT MEDICAL HISTORY**

**Patient Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_

Name of patient’s previous pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and phone number of previous pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient a foster Yes ▢ No ▢ If yes, How long has the patient been in your care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in the home with the patient: Number of Adults\_\_\_\_\_\_\_ Number of Children\_\_\_\_\_\_\_

Please list names and ages of all *adults* in household and relation to patient:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list names and ages of patient’s *siblings*:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_

Pets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of home: Apartment ▢ House ▢ Trailer ▢ Homeless ▢

Smokers in household: Yes ▢ No ▢ Water source: City ▢ County ▢ Well ▢ Bottled ▢

Does the patient attend school or daycare: Yes ▢ No ▢ If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy History:**

Medications/Supplements taken during pregnancy (Please list name and dosage): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Were there any of the following complications during pregnancy:*

Diabetes ▢ Type? \_\_\_\_\_\_\_\_\_\_\_\_\_ Insulin dependent or diet controlled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension ▢ Pre-Eclampsia or Eclampsia ▢

Group B Strep: Pos ▢ Neg ▢ If positive, was adequate treatment received prior to delivery? Yes ▢ No ▢

Vaginal Infections: GC ▢ Chlamydia ▢ HSV ▢ Treated? Yes ▢ No ▢

Street Drugs: Yes ▢ No ▢ If yes, which one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use: Yes ▢ No ▢ If yes, how many drinks per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking/Vaping: Yes ▢ No ▢ If yes, how many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth History:**

How many weeks at delivery: \_\_\_\_\_ Number of previous pregnancies: \_\_\_\_\_\_\_ Living children: \_\_\_\_\_\_\_\_\_

Type of delivery: Vaginal ▢ C-Section ▢

Name of hospital patient was born at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long did patient stay in hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems at delivery or after delivery with patient: Yes ▢ No ▢ If yes, please list? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the patient pass the hearing screen: Yes ▢ No ▢ Did the patient pass the CCHD screen: Yes ▢ No ▢

Did the patient receive medications/vaccine after birth: Vitamin K ▢ Erythromycin eye oint ▢ HepB ▢

Is the patient breastfed or formula fed: Breast ▢ Formula ▢ Name of formula: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have WIC: Yes ▢ No ▢

**Medical History:**

Does the patient have any chronic medical conditions or other issues to be aware of: Yes ▢ No ▢

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are the patient’s immunizations up to date: Yes ▢ No ▢ Do you have the record with you: Yes ▢ No ▢

Any reactions to vaccines/medications in the past: Yes ▢ No ▢ If yes, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient gone to the ER in the last year: Yes ▢ No ▢ If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient ever been hospitalized overnight: Yes ▢ No ▢ If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient ever had surgery: Yes ▢ No ▢ If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have any allergies: Yes ▢ No ▢ If yes, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient take any medications or supplements regularly: Yes ▢ No ▢ If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any specific concerns you would like to discuss with the provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** (Check if any close blood relatives have the following)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Disease** | **Yes** | **No** | **Who?** | **Disease** | **Yes** | **No** | **Who?** |
| Asthma |  |  |  | Heart Attack <55yrs old |  |  |  |
| Sickle Cell Disease |  |  |  | Eczema/chronic skin problems |  |  |  |
| Cystic Fibrosis |  |  |  | Allergies |  |  |  |
| Kidney abnormalities |  |  |  | Anemia/Blood Problems |  |  |  |
| Urinary Tract Infections |  |  |  | Learning Problems |  |  |  |
| Diabetes (List type) |  |  |  | Seizures |  |  |  |
| Sudden, Early,or Unexplained Death |  |  |  | Mental Health Diagnoses |  |  |  |
| Birth Defects |  |  |  | Chronic ear infections |  |  |  |
| Congenital Heart defects |  |  |  | Other significant history? |  |  |  |

I certify that the foregoing information is true and correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature) Date

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual’s protected health information. Individuals completing

this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information. This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form. This authorization shall be in effect for **one year** from the date signed. I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Requesting Information to be sent:** □ FROM or □ TO

Clinic or Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be sent (to or from):**

□ Temple Pediatrics, PLLC, 903 Canyon Creek Dr. Ste 120, Temple, TX 76502, Phone: 855-254-7337

Fax: 855-254-7337

**Information to be included:**

□ Immunization Records □ Growth Chart □ Physical Exam □ Labs/X-ray

□ Diagnostic Test Results (May include HIV, AIDS, Blood Alcohol, Blood Test Results)

□ Complete Chart □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information Necessary for the following purpose:**

□ Continued Patient Care □ Insurance □ Personal Use □ Attorney/Legal □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Please Print) Parent/Guardian (Signature) Date