PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____First Name: _____M:___
Address: _____City:_____
State: ___Zip: _____Phone: (____)_____-_____ Email: _____
Date of Birth: ____/____/_____ Age: _____ SSN: _____-_____-_____
Ethnicity: Hispanic/Latino or Non Hispanic/Non Latino Language: _____
Race: _____ Sex: M____F____
Preferred Contact Method: _____
How did you hear about us? ☐Mail out ☐ Newspaper ☐ Internet ☐ Hospital
☐ Insurance Directory ☐Other: _____

INSURANCE INFORMATION:(ALL information must be completed if applicable)

Primary Ins: _____Policy #_____ PCP: _____
*Policyholder:_____*Date of Birth: _____
Other Insurance: _____Policy #_____

LIST SIBLINGS:_____
_____

PARENT/LEGAL GUARDIAN INFORMATION:
MOTHER'S NAME: _____
Address: _____City:_____
State: ___Zip: _____Home # (____) _____-_____ Work # (____) _____-_____
Date of Birth: ____/____/_____ SSN: _____-_____-_____
Employer: _____
Address: _____City:_____State:__Zip:_____

PARENT/LEGAL GUARDIAN INFORMATION:
FATHER'S NAME: _____
Address: _____City:_____
State: ___Zip: _____ Home # (____) _____-_____ Work # (____) _____-_____
Date of Birth: ____/____/_____ SSN: _____-_____-_____
Employer: _____
Address: _____City:_____State: __Zip:_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS FILED ON MY BEHALF. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN PROVIDING SERVICES.
SIGNATURE: _____ DATE: ____/____/____

THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND I HAVE GIVEN ALL INSURANCE INFORMATION AND I TAKE FULL RESPONSIBILITY FOR ANY CHARGES INCURRED THAT ARE NOT PAID/COVERED BY MY INSURANCE OR THAT ARE RECOUPED DUE TO INSURANCE INFORMATION NOT PROVIDED.
SIGNATURE: _____DATE:____/____/____

ABC Pediatrics
Vaccine Administration Policy

At ABC Pediatrics we are dedicated to providing the highest quality of evidence-based medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP).

These well-respected organizations and committees include panels of experts in pediatrics as well as infectious disease. The goal is to eliminate or minimize preventable serious disease, thereby promoting the health of all children. These national experts routinely analyze available information and research, monitor the prevalence of vaccine-preventable diseases, and analyze reported serious adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect your child. Be aware that there are vaccines used in other countries that are not routinely used in the United States to protect those children from even more diseases.

At ABC Pediatrics we strive to provide the highest quality care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, ABC Pediatrics feels that this decision not only puts your child at risk of serious preventable disease, but also puts the health of others at risk.

Please be advised that if you desire an alternative vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of ABC Pediatrics, the AAP, the AAFP, and the ACIP. We believe that this decision puts your child at risk for vaccine preventable disease and increases health risks for others.

ABC Pediatrics respectfully declines to be your children's pediatricians.

Parents Signature **Date**

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth

*Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, 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 (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. 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 ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Stock No. C-7

Revised 09/2017

Pediatric – Patient Questionnaire

PT Name: _____ Date: _____
Completed By: _____ Relation: _____ Prev. Dr. _____
Reason for today's Visit: _____

PREGNANCY AND BIRTH

Mothers age at pregnancy? _____
Any illness during pregnancy? Y N _____
Medications during pregnancy? Y N _____
_____ (exclude vitamins & iron)
During Pregnancy: **Smoking Alcohol Street drugs**
Was baby: Early # of wks Late On time **Type of Delivery:**
Birth Weight: _____ **Length:** _____
Complications? Y N _____
Problems with Baby at birth? Breathing Y N Jaundice Y N
Other _____
Problems soon after? Nursery or home? _____

Past Medical History: Allergic reactions? Medicine Y N
Food Y N Animals Y N Insect bites Y N
Medication taken on a regular basis? (exclude vitamin) _____
_____
Immunizations up to date? Y N Do you have a record? Y N
Hospitalizations (when-where-why?) _____
_____
Serious Injuries (when-where?) _____

Red Measles	Y N	Mumps	Y N	German Measles (3 day)	Y N
Chicken Pox	Y N	Whooping Cough	Y N	Rheumatic Fever	Y N
Scarlet Fever	Y N	Eczema/Hives	Y N	Seizures	Y N
Anemia	Y N	Hepatitis	Y N	Asthma/Wheezing	Y N
Recurrent Ear Infects (3 or more)			Y N	Throat	Y N
Problems with?		Hearing	Y N	Vision	Y N
Blood Transfusions?			Y N	Bleeding tendency?	Y N

Other? _____

Family Medical History: List all blood relatives of your child who have had the following problems,

Use abbrev. ((F) Father (M) Mother (S) Sister (B) Brother (MM) Mother's Mother (MF) Mother's Father (FM) Father's Mother (FF) Father's Father (A) Aunt (U) Uncle (C) Cousin

Anemia/Blood Dis _____
Asthma _____
Allergies/Sinus _____
Drug Problem _____
Alcoholism _____
Cancer _____
Aids _____
Cystic Fibrosis _____
Musc. Dystrophy _____
Tuberculosis _____
Arthritis _____
Epilepsy/Seizures _____
Heart Disease _____
High Blood Pressure _____
Cholesterol Problem _____
Migraine _____
Sudden Infant Death _____
Birth Defects _____
Early Deafness _____
Diabetes _____
Mental Retardation _____
Mental Illness _____
ADHD _____

Feeding & Nutrition

Food Allergies? _____ Appetite usually good? Y N
Colic or feeding problems during the first 3 months? Y N
Breast feed? Y N Number of Months? _____
Formula? Y N Current Brand? _____
Vitamins? Y N Brand? _____ Fluoride? Y N
Special Diet? _____
Family Profile: Parents (circle): Married – Separated – Divorced - Single
Father's Age? _____ Highest school grade? _____ Health? _____
Mother's Age? _____ Highest school grade? _____ Health? _____
Mother's occupation? _____ Father's occupation? _____
Smoking? Y N Who: _____
Pets? Y N What type of pets? _____
List Child's brothers, sisters and their ages? _____
_____
_____

Development & Behavior

Age at which: Sat Alone _____ Walked _____
Used Sentences _____ Toilet trained _____
Bicycled _____ 'Development compared to other children? _____
Learning Problems? Y N
Gets along with other children? Y N
Behavior Problems? Y N
Speech Problems? Y N
Bad Habits? Y N
Bedwetting? Y N
Nail Biting? Y N Sleeping? Y N
Hobbies - Sports- Social Activities? _____
_____
Use of street or illegal drugs? Y N _____
Grades in school? _____
Problems in School? _____
Language Spoken at Home? _____

ABC Pediatrics

3004 S WS Young Dr.

Killeen, TX 76542

Agreement Regarding Payment and Collection On Accounts

I agree that I am responsible for all amounts not paid/covered by my insurance for medical services rendered by ABC Pediatrics. I further agree that in the event my account is referred to a collection agency for any delinquent amounts owed, I will be responsible for payment of all collection fees charged by that agency in addition to all amounts owed the clinic. I acknowledge this amount is 35% of the total balance due. I further agree that in the event a lawsuit is initiated, I will be responsible for court costs, and attorney fees. Regarding physicals, I am aware that most insurance companies pay for one per year after the age of 2. If my child sees another physician for a physical then comes to ABC for the physical, I will be responsible for any charges incurred.

Signature of Parent/Guardian Date

Agreement Regarding Release of Medical Records

I understand there is a charge for hand carried medical records. This charge is $25 for the first 20 pages and .50 each additional page. I understand that I will have to pay this charge if records are handed to me rather than sent directly to another physician. I further understand that immunization records will be released free of charge one time. Any additional copies will cost $5. Additional charges for forms filled out by the providers will be $7 for the first page, $2 each additional. All charges are to be paid at the time of request

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Signature of Parent/Guardian Date

Agreement Regarding No Shows

I understand that if I no show for 2 consecutive appointments without prior cancellation, I may be discharged from this practice. ABC Pediatrics understands things come up, we just ask that you communicate with us, and call to cancel. I also understand that if I no show to my appointment, I will be responsible for a $25 fee that is an out of pocket expense, not covered by insurance. Everyone's time is valuable. Not showing up, and not canceling is disallowing the chance for another patient who may need an appointment slot.

Signature of Parent/Guardian Date

ABC PEDIATRICS
3004 South WS Young Drive
Killeen, Texas 76542
254-634-7337

January 21, 2019

Attention Parents:

If your child requires a referral, we **MUST** be shown as the Primary Care Physician on your insurance. If your child's insurance shows another provider, we will not be able to place a referral for any specialist. This includes Orthopedics, ENT, Speech Therapy, etc.

If your insurance chooses not to pay for an office visit due to another provider being shown on your insurance, you **ARE** responsible for the bill.

It is the parent's responsibility to keep up to date on who is showing as the PCM on your child's insurance and correct it. We cannot do this for you.

Most Insurances require a referral prior to receiving care from any provider other than your assigned primary Care Provider (PCM) to avoid cost to you. This includes **Urgent Care Facilities and after hours walk-in facilities.** Most Insurance beneficiaries may **ONLY** receive emergency care at **24 hour emergency facilities without a referral from their PCM**.

The on-call ABC Pediatrics clinic provider may be reached by dialing the clinic number after hours 254-634-7337. Please leave a clear and concise **message (containing patients name, patients date of birth, patients symptoms and phone number where you may be reached)** so that the on-call provider may call you back. Blocked calls will not be returned.

OUR CLINIC WILL NOT SUBMIT RETRO REFERRALS

Sincerely,

ABC Pediatrics

_____
Child's Name

_____ _____
Parent's Signature

ABC PEDIATRICS

MANZOOR FAROOQI MD MICAH DAVIS FNP

Authorization for medical treatment of minors

If your child needs medical, dental or hospital services a parent must give permission. It's the law. What if you cannot be reached to give permission? A child may be treated without parental consent when a physician determines a true emergency exists. A true emergency means the child needs immediate medical care and attempting to obtain parental consent would result in a delay that could increase the risk to the child's life or health.

Sometimes, however, a child may need unexpected care which is not a true emergency. In such cases, attempting to contact a parent for permission can delay treatment and create unnecessary anxiety for the child. To alleviate treatment delays, make sure your child's caregivers know how to contact you at all times. When it may be difficult to contact you, you can appoint an adult to consent to medical treatment for your child.

This document allows you to appoint relatives, friends, caregivers—anyone 18 years of age or older—to consent to medical treatment for your child. Complete this form and give it to the adult(s) who have your permission to seek medical treatment. A copy will be placed in your child's medical record. If your child needs medical care, the designated adult should present this document at the time of treatment. It is especially important to prepare this form for those occasions when we may be unable to reach you.

Name of minors	**Date of birth**	**Allergies/special conditions**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I/we, being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint

Name	**Address**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

to authorize unexpected medical, dental, surgical care, and hospitalization for the above named minor(s) during the period of my/our absence, from ***ABC Pediatrics.***

This document shall be presented to a physician, dentist or appropriate hospital representative at the time any unexpected medical, dental, surgical care or hospitalization may be required.

_____	_____	_____
Signature of parent or guardian date	Address	Phone Number
_____	_____	
Signature of witness	date	

Insurance coverage for the above named minor(s) —please include insurance company and policy information

_____

3004 S WS YOUNG DR, KILLEEN, TEXAS
254-634-7337 254-634-2592

ABC Pediatrics

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed ABC Pediatrics' 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.

_____

Print Name of Patient

_____

Date

_____

Signature of Patient, Parent or Guardian

_____

Print Name of Parent or Guardian (if Applicable)

_____

Relationship of Parent or Guardian to Patient

A copy of the Notice of Privacy Practices is available on our website (http://abckilleen.com/bfd_download/nppeng/) for your reference. If you would like to retain a copy of the Notice for your documents, or do not have Internet access, you may keep the copy given to you to read. However, in the interests of conserving our paper resources, please return the Notice if you have no further need for it.

Medical Records Release Form

I authorize _____ (individual or entity, hereinafter known as the "Organization") to release confidential health information by distributing a copy of medical records, or a summary or narrative of the protected health information to ABC Pediatrics.

Patient Name: _____ **Date of Birth:** _____
(Last Name, First Name, MI)

Please release the following health information:

☐ Medical Chart ☐ Immunization Record ☐ Chart & Record ☐ Other (describe)

_____

Limit the release of information subject to this Release Form as follows:

☐ None ☐ One Time Use Only ☐ Limit As Indicated

_____

The reason(s) for this release of information:

☐ Moving Out of Area ☐ Transferring Care Locally ☐ Other (describe)

_____

This authorization shall be in force and effective until the following event and/or date: _____

Disclosures

I understand that additional information about this Medical Release is available from the Organization and that I may obtain a copy of that information from them.

I understand that information disclosed because of this authorization may be divulged by the recipient to others and as such may no longer be protected by federal medical privacy regulations.

I understand that the Organization, and the recipient of the information, will not condition my treatment and payment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the person listed below. I understand that a revocation is not effective to the extent that the Organization has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Releasing entity or person (the "Organization"):

Name: _____

Company: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

FAX: _____ **Phone:** _____

Release the protected health information to:

Dr. _____
ABC Pediatrics
3004 South WS Young Drive
Killeen, Texas 76542
Phone: (254) 634-7337 FAX: (254) 634-2592

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Relationship or Authority of Personal Representative