Northeast Texas Pediatrics

PATIENT

First	Middle	Last	Nickname (if any)	Present Age	Date of Birth

Mailing Address	Social Security #	☐ Male ☐ Female	Primary Phone Number

Race: White Black / African American American Indian Asian Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Other or Undetermined

Preferred Language: English Spanish Other

PARENT/GUARDIAN

Mother's Name		Date of Birth	Primary Phone	Home Work Cell
Address (if different)	Social Security #	Driver's License#	Alternate Phone	Home Work Cell
	Employer		Email Address	
Father's Name		Date of Birth	Primary Phone	Home Work Cell
Address (if different)	Social Security #	Driver's License #	Alternate Phone	Home Work Cell
	Employer		Email Address	
Responsible Party (if parent under 18 years old)		Relationship	Primary Phone	Home Work Cell
Address			Alternate Phone	Home Work Cell

EMERGENCY CONTACTS

Name	Phone
Name	Phone
Name	Phone
Name	Phone

SIBLINGS

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

INSURANCE

Insurance Carrier Policy Holder Name:

Policy Holder DOB: Policy Number:

Group Number: Employer:

Signature of Responsible Party Date

Update Signature Date

Update Signature Date

Update Signature Date

Update Signature Date

2001 Mulberry Avenue Mount Pleasant, Texas 75455 903-577-7337 FAX 903-577-7336

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's 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.

_____
Printed Name of Patient

_____
Patient's Date of Birth

_____
Printed Name of Parent or Guardian

_____
Signature of Patient, Parent or Guardian

_____
Relationship to Patient

_____
Date

PARENTAL CONSENT FOR TREATMENT

In accordance with Texas Law, Northeast Texas Pediatrics, PLLC will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent.

In Texas, a patient is considered a “minor” if he/she is under 18 years, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for the following child in my absence.

_____ _____

Patient/Child Patient/Child Date of Birth

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Signature of Parent/Legal Guardian Date

PATIENT AUTHORIZATION

Patient/Child Name _____Date of Birth_____

Please initial each box.

FINANCIAL RESPONSIBILITY

☐ I will honor the Northeast Texas Pediatrics, PLLC payment policy by payment in full at the time services are rendered. I understand that cash, check or credit card will be accepted for payment.

NO SHOW FEE POLICY

☐ Appointments must be cancelled prior to the visit or a No Show fee of $25 will be charged. No subsequent appointments will be made until this fee has been paid. Any appointment/s scheduled for the morning clinic must be cancelled the previous day. Any appointment/s scheduled for the afternoon clinic must be cancelled by 9:00am of the same day.

AUTHORIZATION FOR CARE

☐ I grant permission for Northeast Texas Pediatrics, PLLC to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ I hereby authorize the Pediatric Clinic, P.A. to release necessary information for the following reasons to other physicians for continuing professional care. I release Northeast Texas Pediatrics, PLLC from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time.

_____ _____

Signature of Parent/Legal Guardian Date

Northeast Texas Pediatrics

Please circle each item that applies to your child:______________________________ DOB:____________

FAMILY HISTORY Is there family history of any of the following:

•ADHD	•Congenital heart disease	•Hepatitis C	•Ovarian cancer
•Alcoholism	•Colon cancer	•Hypertension	•Pancreatic cancer
•Anemia	•Colon polyps	•Hyperlipidemia	•Parental allergies:_____________________
•Arthritis	•Coronary artery disease	•Kidney disease	•Seizures
•Asthma	•Depression	•Learning disability	•Skin cancer
•Bleeding disorder	•Diabetes	•Lung cancer	•Suicide
•Breast cancer	•Heart disease	•Meanoma	•Tuberculosis
•Cervical cancer	•Hepatitis B	•Migraine	•Thyroid disease

SOCIAL HISTORY Do any of the following affect your child:

•History of domestic abuse	•Parents divorced	•Passive smoke – Yes / No
•Religion affecting care	•Lives with grandparents	If yes, explain____
•Foster care	•Adopted	____

PAST MEDICAL HISTORY Has your child ever been diagnosed with any of the following:

•ADD	•Asthma	•Fracture	•Inguinal hernia
•ADHD	•Diabetes	type_________________	•Motor vehicle accident
•Anemia	•Esotropia	•GERD	•Recurrent otitis media
•Apnea	•Exotropia	•Head injury	•RSV
•Appendicitis	•Febrile seizures	•Hepatitis B / C	•Umbilical hernia
		•Hypertension	•Urinary tract infection

PAST SURGICAL HISTORY Has your child had any of the following surgeries:

•Abdominal surgery	•Cholecystectomy	•Knee arthroscopy	•Anesthesia problem – Yes / No
•Adenoidectomy	•Circumcision	•Myringotomy	If yes, explain___________________________
•Appendectomy	•Extra digits	•Post-op delirium	___________________________
•Back surgery	•Hernia-umbilical	•Probed tear duct	•Surgical complications – Yes / No
•Bronchoscopy	•Hernia-inguinal	•Tonsillectomy	If yes, explain___________________________
		•Tonsillectomy & adenoidectomy	___________________________

____ _______________________________

Parent/Legal Guardian Signature Date