Dear Caregiver / Patient,

Welcome to Irving Pediatrics! It is our pleasure to welcome you and your family to our practice and thank you for allowing us to take care of you / your child(ren).

Please complete and bring the following forms with you to your / your child's first appointment:

- ◯ **Patient Registration Form** (updated form must be completed for each child every year)
- ◯ **Medical History** (updated form must be completed for each child every year)

Thank you,
Your Care Team at Irving Pediatrics

DATE: ____________
OFFICE: ____________

IRVING PEDIATRICS PATIENT REGISTRATION FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

Patient Information (*Please list ALL Children Under Age 18*)

Legal Name	Preferred Name	PCP in our Office	Sex (M/F)	DOB (mm/dd/yyyy)	Child lives with? (mother/father/both)

Mother / Father / Guardian #1 (*for child(ren) listed above*)

Name ____
Address ____
City ____
State __________________ Zip Code ____________________
Employer Name _______________________________________

Date of Birth ____
Home Phone (____) ___________________________________
Cell Phone (____) ____________________________________
Work Phone (____) ____________________________________
E-mail address _______________________________________

Mother / Father / Guardian #2 (*for child(ren) listed above*)

Name ____
Address ____
City ____
State __________________ Zip Code ____________________
Employer Name _______________________________________

Date of Birth ____
Home Phone (____) ___________________________________
Cell Phone (____) ____________________________________
Work Phone (____) ____________________________________
E-mail address _______________________________________

Marital Status (circle): Married Single Separated Divorced Widowed

IF DIVORCED: ☐ JOINT CUSTODY ☐ SOLE CUSTODY ☐ LEGAL DOCUMENTS PROVIDED

Address child(ren) live(s) at (*if other than above)*

Address ____ Phone (____) _________________________________

City ____ State _________________________ Zip __________________

Emergency Contact (*other than parent / guardian)*

Name ____ Relationship ____

Home Phone (____) ______________________ Work Phone (____) __________________ Cell Phone (____) _____________________

Authorized Care Givers (*other than parents)*

The following people are authorized to discuss personal health information and to bring my minor child(ren) to Irving Pediatrics for evaluation and treatment, including immunizations:

Name ____ Relationship ____________________ Phone (____) _________________

Name ____ Relationship ____________________ Phone (____) _________________

Name ____ Relationship ____________________ Phone (____) _________________

Name ____ Relationship ____________________ Phone (____) _________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

IRVING PEDIATRICS PATIENT REGISTRATION FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial Irving Pediatrics **(circle one) can cannot** treat and administer injections/vaccines to my unaccompanied child(ren) over the age of 16.

_____ Initial I, ____________________________, authorize Irving Pediatrics to contact me by telephone with medical information pertaining to my child(ren)'s care. If I am unavailable, this authorization gives Irving Pediatrics permission to leave this information either on my answering machine, voicemail, or with a member of my household.

Preferred number to call with information: _______________________________

_____ Initial I authorize Irving Pediatrics, or whomever they designate, to evaluate and treat my above name child(ren) and to release to our insurance company any information acquired in the course of my child(ren)'s examination or treatment, and to receive all payments for such examination or treatment. Irving Pediatrics has my permission to release any diagnostic studies, reports, etc. to a specialist involved in caring for my child.

_____ Initial I understand that all health care decisions, including immunization authorization, must be made by a legal guardian or parent.

_____ Initial A parent / guardian / or authorized care giver is to be present at every visit. If someone else is bringing your child(ren), **we will need prior written authorization** that includes authorization for treatment, your contact information, and insurance and co-pay payment authorization for this visit.

PAYMENT POLICIES

_____ Initial **Insurance Information:** Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, or if the insurance information on file cannot be verified prior to a visit, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billing to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balances:** When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. **<u>You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits.</u>** Irving Pediatrics reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Payments:** Irving Pediatrics accepts cash and credit / debit card payments. Personal checks are not accepted in the office, but are accepted by mail (for statement payments).

_____ Initial **Co-Payments:** Co-payments are expected to be paid at the time service is rendered. If payment is not received at the time of service, there may be an additional fee. All returned checks will be subject to a $40 service charge.

_____ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please ask about the Vaccines for Children program.

_____ Initial **Divorce Situations:** The parent bringing the child in for care is responsible for payment of co-payments. Both parents are responsible for payment on unpaid balances, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

_____ Initial **Referrals:** If your insurance plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral be processed *prior* to the specialist appointment.

_____ Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend, and holiday visits to your insurance carrier. This code may **or may not** be covered.

_____ Initial **No Shows:** A $25 no show fee will be assessed for all visits not canceled one or more **business days** in advance.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

<u>PLEASE COMPLETE BOTH SIDES OF THIS FORM</u>

DATE: ____________
OFFICE: ____________

IRVING PEDIATRICS MEDICAL HISTORY FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

PATIENT NAME: ______________________________ **PATIENT DATE OF BIRTH:** ______________________________

NAME OF PERSON COMPLETING THIS FORM: ______________________________

YOUR RELATIONSHIP TO CHILD: ______________________________ **CHILD'S PREVIOUS DOCTOR:** ______________________________

ALLERGIES or REACTIONS TO MEDICATIONS / FOODS / OTHER AGENTS:

Medication / Allergen	Reaction or Side Effect

MEDICATIONS: List all prescription / non-prescription medicines, vitamins, home remedies, birth control pill, herbs, etc.

Medication	Dose	Times per Day	Medication	Dose	Times per Day

BIRTH HISTORY:

Where was your child born? ______________________________ Is the child yours by: □birth □adoption □stepchild □other
Please indicate any medical problems during pregnancy: ______________________________
Delivery by: □vaginal birth □Caesarean section (Reason for C-section: ______________________________)
Birth weight: ______________________ Birth length: ______________________ APGAR score: 1 min _______5 min _______
Please indicate any medical problems during the newborn period: ______________________________
____
Other problems: ______________________________

PAST MEDICAL HISTORY:

Are your child's immunizations up to date for their age? □ Yes □ No
Describe any major medical problems and their dates: ______________________________
____
____
____
Has your child had any of the following illnesses? □chicken pox □measles □mumps □meningitis □tuberculosis (TB)
Hospitalizations (list dates and reasons): ______________________________
____
____

SURGICAL HISTORY: Please list all prior operations and dates.

Operation	Date	Reason for Operation

PLEASE COMPLETE BOTH SIDES OF THIS FORM

IRVING PEDIATRICS MEDICAL HISTORY FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

FAMILY HISTORY: Please indicate with a check mark any family members who have had any of the following conditions.

Medical Condition	Mom	Dad	Sibling	Gma	Gpa	Medical Condition	Mom	Dad	Sibling	Gma	Gpa
Alcoholism						Genetic diseases					
Anemia						Glaucoma					
Anesthesia Problem						Hay fever / allergies					
Arthritis						Hearing problems					
Asthma						Heart disease					
Birth defects						High cholesterol					
Bleeding problem						Hypertension					
Cancer, breast						Kidney disease					
Cancer, colon						Lupus					
Cancer, lung						Mental retardation					
Cancer, melanoma						Migraine headache					
Cancer, ovary						Mitral valve prolapse					
Cancer, prostate						Osteoarthritis					
Cancer, other						Osteoporosis					
Depression						Psychiatric diseases					
Diabetes, Type 1 (child onset)						Rheumatoid arthritis					
Diabetes, Type 2 (adult onset)						Stroke					
Eczema						Thyroid disorders					
Epilepsy (seizures)						Tuberculosis					

Other Medical Conditions: ____
____

SOCIAL HISTORY:

EXPOSURE / HABITS:

Any concerns about lead exposure? □No □Yes
(old home, plumbing, peeling paint)
Do any household members smoke? □No □Yes

TV hours per day: ________________________________
Computer hours per day: ____________________________
Video game hours per day:

SCHOOL HISTORY:

Does your child attend daycare? □No □Yes
Does your child attend preschool / school? □No □Yes
Current grade level: ________________________________
Name of school: ____________________________________
Any concerns about school performance? □No □Yes

Any concerns about relationship with:
Teachers? □No □Yes
Peers? □No □Yes
If more than 4 years old, does your child have a best friend?
□No □Yes

SPORTS / EXERCISE / HOBBIES:

Type of exercise: ___________________________________
List hobbies: ______________________________________

How often? ____________ How long? ________________
Any concerns? □No □Yes

SAFETY:

Do you use car seats / seatbelts consistently? □No □Yes
Does your child use a bike helmet regularly? □No □Yes
Is violence at home a concern? □No □Yes

Do you have guns in your home? □No □Yes
Other concerns? ___________________________________
____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DATE: ____________
OFFICE: ____________

IRVING PEDIATRICS REVIEW OF SYSTEMS

PATIENT NAME: ____ **PATIENT DATE OF BIRTH:** ____________________________________

NUTRITION / FEEDING:

Is/was your child breastfed? □No □Yes If so, how long? ____________

Milk intake now: □whole milk □2% milk □1% milk □skim milk □soy milk □rice milk

Average ounces per day: ___________________

Has your child had any unusual feeding/dietary problems? □No □Yes (specify: ____)

SLEEP:

How many hours per night does your child sleep, on average? ______________________

How many naps per day does your child take, on average (number and length)? _______________________

Any sleep problems? ____

DENTAL HISTORY:

Has your child been seen by a dentist? □No □Yes If so, how often? ______________ Date of last visit: ______________________

DEVELOPMENT:

At what age did your child: Sit alone? _________ Walk alone? _________ Say words? _________ Toilet train? __________

Females only: Age of first menstrual period? ___________ Date of last menstrual period? _________________

PLEASE CHECK ANY CURRENT PROBLEMS YOUR CHILD HAS ON THE LIST BELOW.

Constitutional
□Fever / chills / sweats
□Unexplained weight loss / gain
□Fatigue / weakness
□Excessive thirst / urination

Eyes
□Squinting / crossed eyes

Ears / Nose / Throat / Mouth
□Difficulty hearing
□Mouth breathing / snoring
□Problems with teeth / gums
□Hay fever / allergies
□Bad breath

Cardiovascular
□Check pain / discomfort
□Tires easily with exertion
□Palpitations

Musculoskeletal
□Muscle / joint pain

Chest (breast)
□Breast lump / discharge

Respiratory
□Cough / wheeze
□Difficulty breathing

Gastrointestinal
□Abdominal pain
□Blood in bowel movement
□Nausea / vomiting / diarrhea

Genitourinary
□Bedwetting
□Pain with urination
□Discharge: penis or vagina

Blood / Lymphatic
□Unexplained lumps
□Easy bruising / bleeding

Skin
□Rash or mole change

Neurological
□Headaches
□Dizziness / light-headedness
□Weakness
□Loss of coordination
□Developmental delay

Psychiatric / Emotional
□Anxiety / stress
□Problems with sleep
□Speech problems
□Depression
□Nail biting / thumb sucking
□Aggressive behavior
□Alcohol / tobacco / drug use

Other (please specify): ____
____

DATE: ____________
OFFICE: ____________

WAIVER FOR SERVICES PROVIDED BY IRVING PEDIATRICS

(One form may be completed for all minors in a single family)

We appreciate you selecting Irving Pediatrics for your family's health care needs. We are committed to quality health care and try to offer comprehensive services on site.

Irving Pediatrics may recommend services that may or may not be a benefit of or fully covered by your insurance plan. Please be advised that any expense not covered by your plan, such as check-ups, screening tests, immunizations, immunization administration, procedures, and laboratory tests will be your responsibility and will be billed to you. These services may also be applied to your annual deductible or co-insurance. Our routine schedule of services follows the recommendations of the American Academy of Pediatrics and the American College of Physicians.

Patients always have the right to choose whether they would like to have the procedures performed in our office. If a patient wishes to have a service performed elsewhere, the appropriate instruction, lab request, or prescription will be given if needed. We ask that you familiarize yourself with your insurance benefits to minimize the possibility of misunderstanding any professional services not covered by your insurance plan.

Please be advised that well child check-ups / annual exams cover preventive care only. Anything that is discussed outside of preventive care, including but not limited to the treatment of chronic conditions and acute illness may be billed to your insurance and assessed a co-pay, deductible, or co-insurance. These fees are the responsibility of the patient.

We utilize your insurance plan's preferred laboratory or imaging facility for additional tests you may need. Please be advised that these facilities will bill your insurance directly. Please contact them directly for any billing questions that may arise due to these services.

By signing below, you acknowledge the above policies and are aware that services not fully covered by your insurance plan will be billed directly to you and are your financial responsibility.

Patient Name / Date of Birth	Patient Name / Date of Birth
Patient Name / Date of Birth	Patient Name / Date of Birth
Patient Name / Date of Birth	Patient Name / Date of Birth
Patient Name / Date of Birth	Patient Name / Date of Birth

Signature of Patient / Parent / Legal Guardian	**Date**

REQUEST FOR RELEASE OF MEDICAL RECORDS

Please **REQUEST** medical information **FROM**:

____
____
____
____
____

Please **SEND** medical information **TO**:

IRVING PEDIATRICS
2000 Esters Rd, Suite 140
Irving, TX 75061
Main: 469-713-3019
Fax: 469-212-1399

Information Requesting (circle all that apply):

All Records — Labs/Radiology
Immunization Records — Physical Form
Insurance Information — Other: ____

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as requested above to Irving Pediatrics as I have indicated. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and/or drug abuse.

HIV/AIDS: I consent to the release of any positive or negative result for AIDS or HIV infection antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: **Initials:**_______________

Release and/or disclose records and information regarding:

PATIENT'S FULL NAME		DATE OF BIRTH		
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE/PREFERRED PHONE	CELL PHONE	E-MAIL ADDRESS		

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purpose:

Reason for records release: ____

A copy of this authorization is valid as an original. I have a right to receive a copy of this authorization. The copy is for me to keep. I understand there may be a fee for preparing and furnishing this information according to rulings set forth by the Texas State Board of Medical Examiners.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN — DATE

PRINTED NAME

The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Health Insurance Portability and Accountability Act (HIPAA) and will be reported as such. I understand that this information will be released within 15 business days of the receipt of the request.