TexomaCare: Patient Registration / Informacion Sobre El/La Paciente

PATIENT INFORMATION / INFORMACION PACIENTE

Patient: Last, first name and middle initial / Garantizador: Apellido, Nombre			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono email: _____
Physical Address / Direccion: Numero Calle Cuidad Estado Zono Postal			
Mailing Address, if different from Physical Address / Otro Direccion			
Employer / Patron De Garantizador			Employer's Telephone # Numero de Telefono del Patron de Garantizador

FINANCIAL INFORMATION, Part I / INFORMACION DEL PACIENTE I

***Responsible party if other than patient**: Last, first name and middle initial / Paciente: Apellido, Nombre *this person would be responsible and receive the bills after insurance responded			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Mailing Address, if different from Patient / Direccion: si es Differente de el Garantizador			Relationship to Guarantor Relacion at Garantizador

RELEASE OF INFORMATION-PLEASE LIST ALL PERSONS AUTHORIZED TO OBTAIN MEDICAL/FINANCIAL INFO

Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:

PATIENT INFORMATION, Part II (if applicable)/ INFORMACION SOBRE EL PACIENTE (si es aplicable)

Patient's Employer / Patron de Paciente	

EMERGENCY CONTACT / EN CASO DE EMERGENCIA

Emergency Contact / En caso de Emergencia Llama	Emergency Contact's Telephone # / Numero de Telefono

Referring Physician:

Family Physician:

Pharmacy preference: **CITY:**

Do you want to be Web Enabled?: ❑ **Yes** ❑ **No** **email address:**

TEXOMACARE

INSURANCE INFORMATION / INFORMACION SOBRE ASEGURANCIA

Primary Insurance **Nombre de la Compania de Asegurancia Primario**	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
Subscriber's Name (who owns the policy) Nombre de Suscriptor	Date of Birth Fecha de Nacimiento	Employer / Patron de Suscriptor	Effective Date Fecha de Valido
Secondary Insurance **Nombre de la Compania de Asegurancia Secundario**	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
Subscriber's Name (who owns the policy) Nombre de Suscriptor	Date of Birth Fecha de Nacimiento	Employer / Patron de Suscriptor	Effective Date Fecha de Valido

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY
MEDICAL PERMISCO para TRATAMIENTO y RESPONSIBLE de PAGOS

The patient agrees to general medical treatment by TexomaCare physicians and understands and consents to the review and use of his/her medical records by any TexomaCare physician. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.
Deside usted que le van a dar tratamiento medico general, por los doctores de TexomaCare y consultar con ostros doctores de TexomaCare. Todos los servicias son la responsabilidad de usted. Lienamos las formas para cobrar a su asegurancia, pero usted es responsable por los cobros. Es costumbre pagar por servicios el mismo dia o tal vez si a hecho otros arregralmentos antes de la cita.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS
PERMISO para ASEGURANCIA y BENIFICCIOS

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

➔**Signature of patient / legal representative:**

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and/or spouse/children may be used and disclosed and how you can get access to this information. I acknowledge that the TexomaCare Notice of Privacy Practices has been provided.

➔**Signature of patient / legal representative**:

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

The authorization form is to give consent to someone(s) other than a parent/legal guardian for the medical treatment of the patient for any unhealthy condition or well visits.

➔**Signature of Parent , Patient or Head of Household** / Garantizador: Apelido, Nombre	**Date** / Fecha de Firma

OFFICE USE

Data Collected by Whom:	Date of Data Collection:	Data Entered by Whom	Date of Data Entered:

TEXOMACARE

PATIENT INFORMATION

Chart #: _____

PEDIATRIC PATIENT PERSONAL HISTORY

Confidential Record: Information will not be released without the permission of parent or guardian.

Patient's Name: _____ Age: _____

Pregnancy and Birth

- Mother's age when pregnant _____
- Obstetrician's name: _____
- Did mother have any illness or infection during pregnancy? Y **N**
- Did she take any medications other than vitamins and iron? Y **N**
- Did mother use recreational drugs, alcohol or tobacco? Y **N**
- Was the baby on time? **Y** N
- Were there any problems with labor or delivery? Y **N**
- Type of delivery? __ Cesarean Section __ Vaginal Delivery
- What was the birth weight? _____
- Did the baby have any problems at birth? Y **N**
  If yes, please explain. _____
- How many days did the mother and child stay in the hospital?
  Mother: _____ Child: _____
- Where was the infant born? __ Hosp. __ Home __ En route to hosp.

Past Medical History

- Where has your child gone for check-ups before today?
  _____
- Date of last medical check-up? _____
- Date of last dental check-up? _____
- Date of last eye exam? _____
- Has your child had allergic reactions to any medications? Y **N**
  If yes, what medications: _____
- Has your child had allergic reactions to any foods? Y **N**
  If yes, what foods: _____
- Has your child had allergic reactions to any insect bites? Y **N**
  If yes, what insects: _____
- Has your child had reactions to any immunizations? Y **N**
  If yes, which ones: _____
- Has your child been hospitalized at any time other than birth? Y **N**
  If yes, for what: _____
- Has your child had any serious injuries? Y **N**
  If yes, what kind: _____
- Are any medications taken regularly? Y **N**
- If yes, which ones: _____

Family History

- Are the child's parents both in good health? **Y** N
- Circle any diseases that this child/s parents, grandparents, brothers, sisters, aunts or uncles have or had: asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS/HIV carrier, others: _____
- _____
- Have any of the child's brothers or sisters died? Y **N**
  If yes, from what: _____

Feeding and Nutrition

- Is your child's appetite usually good? **Y** N
- Is it good now? **Y** N
- Was there severe colic or any unusual feeding problems during the first three months? Y **N**
- Do any foods disagree with your child? Y **N**
- During the first year is/was your child __ breast fed or __ bottle fed?
- Is your child still on formula? Y N
- Does your infant/child take vitamins? Y N
- fluoride? Y N
- Is your water supply fluoridated? **Y** N

Review of Systems

- Has your child had frequent ear infections? Y **N**
- Has your child had any hearing problems? Y **N**
- Has your child had any problems with teeth? Y **N**
- Any eye problems (seeing or with eyes)? Y **N**
- Is there asthma, pneumonia, or recurrent cough? Y **N**
- Does he/she have a heart murmur or any heart problems? Y **N**
- Are there any problems with urination? Y **N**
- Any problems with diarrhea or constipation? Y **N**
- Have there been any convulsions or other problems with the nervous system? Y **N**
- Any eczema, hives, or other skin conditions? Y **N**
- Has your child ever been anemic (low blood)? Y **N**
- Please list any other medical problems: _____
- Has your child experienced any of the following conditions / injuries? __ chicken pox __ eating paint __ broken/fracture bones

Development and Behavior

- Has the child done things at the same time as his siblings or friends? **Y** N
- At what age did your child sit alone? _____
- At what age did your child walk alone? _____
- Did your child say any words by the time he/she was 1 ½ years old? **Y** N
- Does your child have any problems sleeping? Y **N**
- What grade is your child in? _____
- Has your child ever failed a grade? Y **N**
- Has your child had any behavioral problems in school? Y **N**
- Does your child get along with other children? **Y** N
- Check if your child has had any of the following:
- __ nail biting __ thumb sucking __ bed wetting
- __ lie a lot __ hyperactivity __ nightmares
- __ speech problems __ problems with discipline
- __ overly nervous __ steal __ overly shy
- __ easily upset __ jealous

Safety and Environment

- Do you live in a __ private house, __ apartment,
- __ mobile home or other: _____?
- Do you know the hottest temperature of the water in your pipes? **Y** N
- Is there a working smoke alarm on each floor of your house? **Y** N
- Does your child always use a car seat/seat belt when riding in a car? **Y** N
- Does your child use a tooth brush daily? **Y** N
- Are there any smokers in the household? Y **N**
- Are there any problems with the conditions of your home? (peeling paint, insects, rats or mice) Y **N**
- Are there any guns or weapons kept in the house? Y **N**
- Does your child wear a helmet when riding a bike? Y **N**
- Do you have pets in the home? Y **N**

Do you have a record of immunizations? Y N

Physical History

- Who lives in the home with the child? (complete chart-next page)
- Who takes care of the child on a typical day? _____
- Does your child regularly spend time with a baby sitter or at a day care? Y N
- If yes, how many time per week and hours per day?
  _____

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Chart #: _____

We would like to know who lives in the home with the child.

Name	Relationship	DOB	Health

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TexomaCare-Pediatrics and Adolescent Medicine
5012 S. US Hwy 75, Suite 300
Denison, Texas 75020
903.416.6200
Fax – 903.416.6201

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

State of: _____

County of: _____

I, _____ (Parent/Guardian Name), parent/guardian of _____ (Child's Name) a minor child

born on _____ / _____ / _____ hereby authorize:

_____ Name of authorized individual and relation to patient

_____ Name of authorized individual and relation to patient

_____ Name of authorized individual and relation to patient

_____ Name of authorized individual and relation to patient

to give consent for the medical treatment of the above named child for any unhealthy condition that he/she may encounter. I also authorize the physicians and professionals at TexomaCare to give information to the individual named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child. I hereby release TexomaCare of any liability regarding release of this information on the above named child.

I hereby authorized my child (ages 16 and 17 only) to receive medical treatment without an authorized person accompanying him/her. _____ initial

Executed this _____ day of _____, 20___.

_____
Parent/Guardian Name - Print

_____
Parent/Guardian Name – Signature

_____
Witness Signature

☐ Original is scanned and filed in chart as well as notated in the EHR system*

TEXOMACARE

Patient: _____ Date of Birth: _____

Consent for Treatment

The patient agrees and consents to general medical treatment by TexomaCare professionals and consents to the review and use of his/her medical records which includes the history from RXHub by any TexomaCare physician.

Understanding of Financial Responsibility

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment of Insurance Benefits

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician or extender. I further understand and agree that this agreement remains in force until revoked by me in writing.

HIPPA-Notice of Privacy Practices

This notice describes how medical information about the patient may be used and disclosed and how I can access to this information. Per my signature below, I acknowledge that the TexomaCare Notice of Privacy Practices has been provided to me if requested.

Signature: _____ **Date:** _____