Dallas Pediatrics
2020 N Masters, Suite 100
Dallas, TX 75217
Email Dallaspedsclinic@gmail.com
Phone 972-984-2001
Fax 972-984-2004

PATIENT INFORMATION

INFORMACIÓN DEL PACIENTE

Patient's Name: _____ Date of Birth_____
Social Security #_____-_____-_____
Address: _____
City:_____ State:_____ Zip Code: _____
Home Phone/Cell Phone: _____ Sex: _____M _____F

RESPONSIBLE PARTY

Name: _____ Date of Birth _____ Social Security #_____-_____-_____ Address:
_____
City:_____ State: _____ Zip Code: _____
Home Phone:_____ Cell Phone:_____
Employer's Name:_____ Work Phone:_____ Employer's
Address:_____
City:_____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Name of Insurance:_____
Policy# _____Group#_____

Name of Card Holder:_____ Relationship to Patient:_____

Social Security#_____ D.O.B:_____ Insurance Phone#_____

MEDICAID/CHIP INFORMATION

Type of Insurance _____ Regular/Traditional Medicaid _____ Amerigroup _____
Texas Health Network _____ Parkland _____ Cooks Children's _____ Other _____
Member#_____

EMERGENCY CONTACT

Name: _____ Date of Birth: _____Relationship to Patient:_____
Address:_____City:_____State:_____Zip Code:_____ Home
Phone:_____ Work Phone: _____Cell Phone:_____
Email address: _____
Who referred you to our practice? _____

TODAY'S DATE: _____

Important *Please fill out both, if you have more than one insurance company.

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PATIENT DISCLOSURES AND CONSENTS INSURANCE BENEFITS/PAYMENTS:

I authorize direct payment of insurance benefits to Dallas Pediatrics for services rendered to my dependents. I agree to pay any copayments, deductibles, or any balance that the clinic is unable to collect from my insurance company. I understand that it is my responsibility to pay for the services that I have requested and receive that are not determined to be medically necessary by the physician or insurance company.

*Initials_____

PROTECTED HEALTH INFORMATION:

I certify that I have acknowledged and read a copy of the Dallas Pediatrics. “Notice of privacy practices.”

This notice describes how the clinic may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information and my rights regarding such information.

I authorize the clinic to release and receive any of my dependents medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. I understand the privacy risk of the mail, phone calls, and email. I authorize the staff of Dallas Pediatrics to mail, call, or email me with communication regarding medical care, including but not limited to appointment reminders, medical and insurance information.
I understand that I have the right to revoke this authorization at any time by notifying the clinic in writing.

*Initials_____

Name of Parent/Guardian _____

Signature of parent/guardian _____

Date _____

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MEDICAL HISTORY
HISTORIAL MÉDICO

Patient's Name:_____ D.O.B_____

Birth History:
Birth Weight:_____ Birth Length: _____ Gestational Age:_____
Birth Place:_____ Pregnancy Complications:_____ Delivery: Vaginal _____
C-Section_____ Complications_____ Development History: _____ Normal _____ Delayed
Previous Hospitalizations:_____
Previous Surgeries:_____
Allergies:_____
Current Medications:_____
Family History:_____
Does your child have, or has had, any of the following? (Yes/No)

____ ____ Anemia ____ ____ Hemophilia ____ ____ ADD/ADHD ____ ____ Hepatitis A, B, C ____ ____

Asthma ____ ____ High blood pressure ____ ____ Blood disorder/Leukemia ____ ____

Kidney problems ____ ____ Chest pains ____ ____ Liver problems ____ ____ Convulsions/seizures ____ ____

Lung disease ____ ____ Diabetes ____ ____ Psychiatric problems ____ ____ Drug addictions ____ ____

Weight loss ____ ____ Excessive thirst ____ ____ Scarlet fever ____ ____ Fainting spells/dizziness ____

Sickle cell trait/disease ____ ____ Frequent/chronic cough ____ ____ Venereal disease ____ ____

Frequent headaches ____ ____ Thyroid disease ____ ____ Heart murmur ____ ____
Tumors or growths ____ ____ Heart problems ____ ____ Ulcers ____ ____ Stomach/intestinal problems

To the best of my knowledge, the questions on this form have accurately been answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform the clinic of any changes in my child's medical status.

Signature of parent/guardian _____ _____

Date _____ _____

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Pharmacy Information

Información de farmacia

Pharmacy Name: _____

Pharmacy Phone Number: _____

Address: _____

Authorized Parent/Guardian

Padres o guardianes Autorizados

(Who may also bring children to clinic)

**** IMPORTANT: MUST BRING PHOTO ID

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please list 3 other individuals with their phone numbers who we may release medical information to, other than yourself.

*** IMPORTANT: BRING PHOTO ID

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name of Parent/Guardian _____

Signature of parent/guardian _____ Date _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth_____
Phone (H) _____ Phone (C) _____
Address: _____
City:_____ State:_____ Zip Code: _____

Above listed patient authorizes the following health care facility to make record disclosure
Facility Name: _____
Facility Phone: _____ Facility FAX: _____
Facility Address: _____
City, ST, Zip: _____ _____ _____

The purpose of disclosure or physician
_____ Change if Insurance of Physician
_____ Referral
_____ Other

This information may be disclosed and used by the following individual or organization:

Released to:

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I understand that authorization for the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosures.
I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of parent/guardian Date

_____ _____
Printed Name of authorized Representative Relationship/capacity to patient