PATIENT

Child's Full Name_____

Address_____

City_____ State_____ Zip_____

Sex M F Date of Birth_____/_____/_____

Who referred patient? _____

*If the New Patient is not a new born immunizations must be provided before the patient's first well child appointment.

Brother or Sister's Name_____ Sex: M F DOB: _____/_____/_____

Brother or Sister's Name_____ Sex: M F DOB: _____/_____/_____

Brother or Sister's Name_____ Sex: M F DOB: _____/_____/_____

PARENT 1

Parent's Full Name _____ Date of Birth _____

Parent's Home Address (if different from above) _____

Parent's EMAIL _____

Cell Phone # _____ SSN# _____-_____-_____

Driver's License # _____ State _____ Exp. Date _____

PARENT 2

Parent's Full Name _____ Date of Birth _____

Parent's Home Address (if different from above) _____

Parent's EMAIL _____

Cell Phone # _____ SSN# _____-_____-_____

Driver's License # _____ State _____ Exp. Date _____

EMERGENCY

Name of Person **NOT** living with Child _____

Home Telephone # _____ Cell Phone #_____

Relationship to Child _____

There may be times when you have a friend, relative, or nanny bring your child to the doctor. Please designate those people who you authorize to bring your child to our office, call our office, and/or have access to his or her medical information.

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

INSURANCE

We **MUST** have a copy of your insurance card.

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Policy Number _____ Group Number _____ Copay _____

Patient's Relationship to Subscriber: (Circle One) Self Child

Subscriber's full name _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone # _____ Alternate Phone # _____

Date of Birth _____/_____/_____ SSN# _____ - _____ - _____

Please sign to verify that all information above is correct and valid.

_____

Name of Child

_____

Date

X _____

Signature of Parent or Guardian

PAST MEDICAL HISTORY

Child's Name _____

Place of Birth _____ Birth Weight _____

Pregnancy and Birth Problems _____

Prior Hospitalizations _____

Prior Surgeries _____

Chronic Medical Problems _____

Food or Medication Allergies _____

FAMILY HEALTH PROBLEMS: IDENTIFY PROBLEM AND RELATIONSHIP TO CHILD

Description	Problem	Relationship to Child
SKIN (Dermatitis, Birthmarks, Etc)		
EYE, EAR, NOSE, THROAT (Visual, Hearing, Infections, Allergies, Cleft Lip)		
LUNGS (Asthma, Tuberculosis, Emphysema, Reactive Airways Disease)		
IMMUNOLOGIC (Receiving Chemotherapy or Steroids, AIDS)		
HEART (Heart Disease, Stroke, High Blood Pressure, High Cholesterol)		
BLOOD DISORDERS (Anemia, Sickle Cell Disease)		
STOMACH (Ulcers, Pyloric Stenosis, Liver Disease, Diarrhea, Constipation)		
KIDNEY (Urinary Tract Infections, Renal Failure)		
ENDOCRINE (Thyroid Disease, Diabetes)		
BONE/MUSCLE (Dislocated Hip, Arthritis, Scoliosis)		
NERVOUS (Headaches, Seizures, Learning Problems, Mental Illness, Mental Retardation)		
OTHER (Cancer, Obesity, Cystic Fibrosis, Birth Defects, Alcoholism)		

Park Cities Pediatrics

PAYMENT POLICY

1. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the full amount of a claim. Please bring your insurance card to every visit and notify us of any new changes.

2. All co-payments, co-insurance and deductibles must be paid at time of service as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience, we accept MasterCard, Visa, Discover and American Express. You may make credit card payments via the phone. Hot check writers will be charged a $30 fee and may be referred to the Dallas County District Attorney's office and/or sent to our collection agency.

3. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days, we will require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you.

4. Please be aware that some of the services you receive may not be covered by your insurance company. You will be responsible for payment of all charges for services not covered by your insurance company.

5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when cancelling an appointment. If you do not give adequate notice, you may be charged $25.00.

6. Self-pay families will receive a prompt pay discount, which is due at the time of service.

7. Families with higher balances or extreme circumstances may contact our office to discuss a payment plan.

8. Statements are sent monthly. To save on postage, we do not bill for balances less than $5.00. Credits will be applied to your next visit.

_____ _____

Signature of Parent or Guardian Date

_____

Patient Name

Park Cities Pediatrics

CONSENT TO TREAT

I give consent for diagnosis and treatment to Park Cities Pediatrics to provide medical care reasonable by today's standards to my minor child. This includes, but is not limited to: physical examination, evaluation of illness and injuries, routine immunizations, lab testing and minor procedures. Verbal consent will be obtained prior to each immunization. Vaccine information sheets are available upon request.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review a copy of the Notice of Privacy Practices which explains how your medical information will be used and disclosed. This is posted in the office and a copy is available upon request.

CARE EVERYWHERE CONSENT

Care Everywhere is a way to receive and send medical records electronically with other facilities that have the same medical records program. By signing below you authorize Park Cities Pediatrics to receive/send medical records when they are available or needed.

☐ I do **NOT** want to participate in Care Everywhere

ASSIGNMENT OF BENEFITS

I hereby assign Park Cities Pediatrics all right, title, and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to Park Cities Pediatrics and I will be responsible for any charges accrued and not paid by the insurance company. I am responsible for all co-pays, deductibles, co-insurance and non-covered services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my child's medical information by Park Cities Pediatrics to any consulting physician, hospital, and third-party payers such as insurance companies, government agencies, self insurance employer or utilization review organization.

This document remains in effect unless revoked in writing.

_____

Child's Name

X _____ _____

Signature of Parent/Guardian **Date**

8215 Westchester, Suite 150 • Dallas, Texas 75225 • 214.361.7185 • www.parkcitiespediatrics.com

Park Cities Pediatrics

Matthew L. Simon, MD

8215 Westchester Dr Suite 150 Dallas, Texas 75225
Phone: 214-361-7185 Fax: 214-373-4841

PATIENT'S NAME: _____ **DATE OF BIRTH:** ____/____/____

(CHECK THE BOX THAT APPLIES)

[ ] **I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS; EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASE TO THE FOLLOWING:**

1. _____
2. _____
3. _____

[ ] **INFORMATION IS NOT TO BE RELEASED TO ANYONE.**

SIGNED: _____ **DATE:** _____

WITNESSED: _____ **DATE:** _____

****THIS RELEASE WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.**

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.**