

# WESTSIDE PEDIATRICS

707 S FRY RD, SUITE 275

KATY TX 77450

PHONE: (281) 578-5788    FAX: (281) 578-8008

## NEW PATIENT INFORMATION

Child's Name:	Gender: M / F	Date of Birth:    /    /
Address:	Home Phone:	
City:	ZIP Code:	
Name of Subdivision / Apartment Complex:	E-mail Address	
Referred by:		
Name of Father / Legal Guardian:	Name of Mother / Legal Guardian:	
Date of Birth:    /    /	Date of Birth:    /    /	
Drivers License #:	Drivers License #:	
Occupation:	Occupation:	
Employer:	Employer:	
Work Phone:	Work Phone:	
Cell Phone:	Cell Phone:	
Insurance Co. Name:	Insurance Co. Name:	
Policy #                      Group #	Policy #                      Group #	
Mailing Address:	Mailing Address:	
City & State:	City & State:	
Names & Ages of Other Children:	Names & Ages of Other Children:	
Name of Previous Physician:	Name of Previous Physician:	

### PAYMENT IS DUE WHEN SERVICES ARE RENDERED

Person Responsible for Payment:	Emergency Notification Contact:
Address and Phone Number:	Emergency Phone Number:

**REQUEST FOR RELEASE AND TRANSFER OF  
PATIENTS RECORDS TO WESTSIDE PEDIATRICS**

The undersigned \_\_\_\_\_  
PRINTED NAME OF LEGAL GUARDIAN/PARENT

SSN: \_\_\_\_\_ legal Guardian/Parent of \_\_\_\_\_  
PARENTS SOC. SEC. # PRINTED NAME OF PATIENT

DOB: \_\_\_\_\_, Hereby authorizes and requests:  
PATIENT'S DATE OF BIRTH

\_\_\_\_\_  
NAME OF PATIENT'S PREVIOUS PHYSICIAN OR GROUP

\_\_\_\_\_  
ADDRESS OF PREVIOUS PHYSICIAN OR GROUP

\_\_\_\_\_  
PHONE NUMBER OF PREVIOUS PHYSICIAN OR GROUP

To release and transfer Patient records at their earliest convenience to:

**WESTSIDE PEDIATRICS  
707 SOUTH FRY RD. SUITE 275  
KATY, TX 77450  
PH: (281) 578-5788  
FAX: (281) 578-8008**

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

**\*PLEASE FAX SHOT RECORDS TO 281-578-8008 WITHIN 24 HOURS OF THIS NOTICE ALL OTHER  
RECORDS CAN BE MAILED. Thank you.**

(Please type or print clearly.)

(Sírvase escribir claramente a máquina o con letra de molde.)

Child's Last Name / Apellido del niño(a)

Child's First Name / Nombre del niño(a)

Child's Middle Name / Segundo nombre del niño(a)

Child's Date of Birth / Fecha de nacimiento del niño(a)

\* Children under 18 years only / Solamente niños menores de 18 años

Child's Gender / Género:  Male / Masculino  Female / Femenino

Mother's First name / Nombre de la madre

Mother's Maiden Name / Nombre de soltera de la madre

Child's Address / Dirección del niño(a)

Apartment # / Apartamento #

Telephone / Teléfono

City / Ciudad

State / Estado

Zip Code / Código postal

County / Municipio

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud. El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño para asegurar que las vacunas importantes no le falten.

*The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.*

*El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.*

**Consent for Registration of Child and**

**Release of Immunization Records to Authorized Entities**

I understand that by granting consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the consent to include information on my child in the ImmTrac Registry and my consent to release information from the registry at any time by written communication to the Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

**Consentimiento Para Registrar al Niño(a) y Para Poder Dar a Conocer a Entidades Autorizadas el Récord de Inmunizaciones del Niño(a)**

Entiendo y acepto que al autorizar mi consentimiento en la parte inferior, registro a mi niño(a) en el registro de inmunización del Departamento Estatal de Servicios de Salud de Texas y autorizo al registro para que incluya la información de mi niño(a) en el registro y que el récord de inmunizaciones de mi niño(a) del pasado, presente y futuro sea dado a conocer a alguno de los padres del niño(a), y a cualquiera de los siguientes:

- distrito de salud pública o departamento de salud local;
- médico o proveedor de atención de salud;
- compañía de seguros, organización para el mantenimiento de salud o pagador;
- escuela o centro de cuidado de niños, en el que el niño(a) está inscrito y/o
- agencia estatal que tenga custodia legal del niño.

Reconozco y acepto que en cualquier momento puedo retirar mi consentimiento de poder incluir la información de mi niño(a) en el Registro ImmTrac, y también retirar mi consentimiento para poder dar a conocer la información del registro, por medio de comunicación escrita dirigida al Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

By my signature below, I **GRANT** consent for registration. I wish to **INCLUDE** my child's information in the Texas immunization registry.  
 Al firmar abajo, YO **AUTORIZO** el consentimiento para registrarlo. Deseo **INCLUIR** la información de mi niño en el registro de inmunización de Texas.

Parent, legal guardian, or managing conservator:

Alguno de los padres, tutor legal o administrador de bienes:

Printed Name / Escriba con letra de molde

Date / Fecha

Signature / Firma

**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.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

**Notificación Sobre Privacidad:** Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. Usted se lo debe conocer el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta.  
 Diríjase a <http://www.dshs.state.tx.us> para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Questions? / ¿Tiene preguntas? (800) 252-9152 • (512) 458-7284 • [www.ImmTrac.com](http://www.ImmTrac.com)  
 Texas Department of State Health Services • ImmTrac Group - MC 1946 • 1100 West 49<sup>th</sup> St. • Austin, TX 78756

Stock No. C-7  
 Revised 05/25/05



**PROVIDERS REGISTERED WITH ImmTrac** – please fax this signed (by parent) Consent Form to ImmTrac **only if the child is not currently registered with ImmTrac.**  
 Fax to: (512) 458-7290 (Austin) or toll free (866) 624-0180.

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

M F

## Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. \_\_\_\_\_

If mother and father are not living together or if child does not live with parents, what is the child's custody status? \_\_\_\_\_

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? \_\_\_\_\_

## Birth History

Birth weight \_\_\_\_\_

Was the delivery  Vaginal?  Cesarean?

Was the baby born at term? \_\_\_\_\_ Early? \_\_\_\_\_ Late? \_\_\_\_\_

If cesarean, why? \_\_\_\_\_

If early, how many weeks' gestation? \_\_\_\_\_

Did your baby have any problems right after birth?

Did mother have any illness or problem with her pregnancy?

Yes  No Explain \_\_\_\_\_

Yes  No Explain \_\_\_\_\_

Was initial feeding  Breast?  Bottle?

During pregnancy, did mother

Smoke  Yes  No

Drink alcohol  Yes  No

Use drugs or medications  Yes  No

What \_\_\_\_\_ When \_\_\_\_\_

Did your baby go home with mother from the hospital?

Yes  No Explain \_\_\_\_\_

## General

Do you consider your child to be in good health?

Yes  No Explain \_\_\_\_\_

Does your child have any serious illness or medical condition?

Yes  No Explain \_\_\_\_\_

Has your child had serious injuries or accidents?

Yes  No Explain \_\_\_\_\_

Has your child had any surgery?

Yes  No Explain \_\_\_\_\_

Has your child ever been hospitalized?

Yes  No Explain \_\_\_\_\_

Is your child allergic to any medicines or drugs?

Yes  No Explain \_\_\_\_\_

## Development

Are you concerned about your child's physical development?

Yes  No Explain \_\_\_\_\_

Are you concerned about your child's mental or emotional development?

Yes  No Explain \_\_\_\_\_

Are you concerned about your child's attention span?

Yes  No Explain \_\_\_\_\_

If your child is in school:

How is his/her behavior in school? \_\_\_\_\_

Has he/she failed or repeated a grade in school? \_\_\_\_\_

How is he/she doing in academic subjects? \_\_\_\_\_

Is he/she in special or resource classes? \_\_\_\_\_



WESTSIDE PEDIATRICS, P.A.

PEDIATRIC CONSENT FOR CARE

For the privacy and confidentiality of our patients, please list the names of individuals who have the right to bring your child into the clinic.

I, \_\_\_\_\_ give the following people  
(Name of parent/guardian)  
permission to make medical decisions and rights to confidential information (please include the name of the second parent):

<u>Name</u>	<u>Relationship to patient</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

On a new patient visit, the patient must be accompanied by a legal guardian. A picture ID will be checked at each appointment. If one of the above individuals is not listed, then verbal permission by a legal guardian must be given over the phone. Please write contact numbers here of legal guardians:

<u>Name</u>	<u>Phone Number/Location</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**PATIENT / PARENT / GUARDIAN CONSENT  
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, **WESTSIDE PEDIATRICS, P. A.**, may use and disclose protected health information (PHI) about \_\_\_\_\_, hereinafter referred to as "Patient", to carry out treatment, payment and healthcare operations (TPO). Please refer to **WESTSIDE PEDIATRICS'** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **WESTSIDE PEDIATRICS** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**WESTSIDE PEDIATRICS,**  
707 S. Fry Rd, Suite 275  
Katy TX 77450  
Attn: Office Manager

With my consent, **WESTSIDE PEDIATRICS** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to Patient's clinical care, including laboratory results among others.

With my consent, **WESTSIDE PEDIATRICS** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **WESTSIDE PEDIATRICS** restrict how it uses or discloses Patient's Protected Health Information (PHI) to carry out treatment, payment and healthcare operations (TPO). However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **WESTSIDE PEDIATRICS'** use and disclosure of Patient's PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **WESTSIDE PEDIATRICS** may decline to provide treatment to Patient.

\_\_\_\_\_  
Signature of Patient or Patient's Parent or Guardian

\_\_\_\_\_  
Printed Name of Authorized Signer

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date