

REGISTRATION SHEET • HOJA DEL REGISTRO

PLEASE PRINT/ FAVOR DE IMPRIMIR

Today's Date/ Fecha: _____

PATIENT INFORMATION (MINOR CHILD)

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

Male/ Niño **Female/ Niña** **Last / Apellido** _____ **First / Primer Nombre** _____ **MI / Inicial** _____

Date of Birth/ Fecha de Nacimiento ____/____/____ **SS#/ Número de Seguridad Social** _____

Address/ Dirección _____ **City/ Ciudad** _____ **State/ Estado** _____ **Zip/ Código** _____

Siblings/ Hermanos(as)

Name/ Nombre _____	Date of Birth/ Fecha de Nacimiento ____/____/____
Name/ Nombre _____	Date of Birth/ Fecha de Nacimiento ____/____/____
Name/ Nombre _____	Date of Birth/ Fecha de Nacimiento ____/____/____
Name/ Nombre _____	Date of Birth/ Fecha de Nacimiento ____/____/____
Name/ Nombre _____	Date of Birth/ Fecha de Nacimiento ____/____/____

PARENT INFORMATION (PERSON RESPONSIBLE FOR BILLS)

Name/ Nombre _____ **Relationship to Patient/ Relación al paciente** _____

Date of Birth/ Fecha de Nacimiento ____/____/____ **SS#/ Número de Seguridad Social** _____

Address/ Dirección _____ **City/ Ciudad** _____ **State/ Estado** _____ **Zip/ Código** _____

Home Phone/ Teléfono Casero _____ **Cell/ Célular** _____ **Work/ Trabajo** _____

Employer Name/ Nombre de Trabajo _____

Employer Address/ Dirección de Trabajo _____ **City/ Ciudad** _____ **State/ Estado** _____ **Zip/ Código** _____

PRIMARY INSURANCE INFORMATION

Insured Party Employer (Employee)/ Empleado _____

Last / Apellido _____ **First / Primer Nombre** _____ **MI / Inicial** _____

Date of Birth/ Fecha de Nacimiento ____/____/____ **Relationship to Patient/ Relación al paciente** _____

Address/ Dirección _____ **City/ Ciudad** _____ **State/ Estado** _____ **Zip/ Código** _____

SS#/ Número de Seguridad Social _____ **DL#/ # de Licencia** _____ **State/ Estado** _____

Employer Ins. Plan?/ ¿Régimen de seguros de trabajo? YES/Si NO

Insured Party's Employer/ Empleador _____ **Plan Name/ Nombre del plan** _____

Policy / ID#/ Política _____ **Group #/ # de Grupo** _____

Home Phone/ Teléfono Casero _____ **Cell/ Célular** _____ **Work/ Trabajo** _____

ADDITIONAL INSURANCE INFORMATION

Insured Party Employer (Employee)/ Empleado _____

Last / Apellido _____ **First / Primer Nombre** _____ **MI / Inicial** _____

Date of Birth/ Fecha de Nacimiento ____/____/____ **Relationship to Patient/ Relación al paciente** _____

Address/ Dirección _____ **City/ Ciudad** _____ **State/ Estado** _____ **Zip/ Código** _____

SS#/ Número de Seguridad Social _____ **DL#/ # de Licencia** _____ **State/ Estado** _____

Employer Ins. Plan?/ ¿Régimen de seguros de trabajo? YES/Si NO

Insured Party's Employer/ Empleador _____ **Plan Name/ Nombre del plan** _____

Policy / ID#/ Política _____ **Group #/ # de Grupo** _____

Home Phone/ Teléfono Casero _____ **Cell/ Célular** _____ **Work/ Trabajo** _____

PARENTAL CONSENT INFORMATION

I, _____ give permission for
Yo, _____ Parent/ Legal Guardian/ Padre doy permiso para que

_____ to seek medical treatment for my child in my absence.
_____ Recibir tratamiento médico para mi hijo(a) sin mi presencia.
Executor/ Ejecutor **Relationship to Child/ Relación al niño**

Witness/ Testigo _____ **Date/ Fecha** _____

Emergency Contact Name _____	Relationship _____	Phone Number _____
Nombre de contacto de la emergencia	Relación	Número de teléfono

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the Physician of the surgical and/ or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay for non-covered services.

I also authorize the Physician to release any information acquired in the course of treatment necessary to process insurance claims.

Signature (Patient or Parent if Minor) / Firma **Date/ Fecha**

PATIENT MEDICAL HISTORY • HISTORIAL MÉDICO PACIENTE

Child's Name _____

Birth Date ____/____/____

Age _____

Nombre del niño/niña

Fecha de nacimiento

Edad

FAMILY / FAMILIA

Mother's Age _____ Occupation _____

Edad de la madre

Ocupación

Father's Age _____ Occupation _____

Edad del padre

Ocupación

Siblings/Hermanos	Age/Edad	Sex/Sexo	Health/Salud

ANY FAMILY HISTORY OF:

ALGUIEN EN SU FAMILIA TIENE UN HISTORIAL DE:

What / ¿Qué?	Who? / ¿Quién?
Alcoholism/Alcoholismo	
Allergies/Alergias	
Anemia	
Asthma/Asma	
Birth Defects/Defectos de Nacimiento	
Cancer/Cáncer	
Cystic Fibrosis/Fibrosis Cística	
Diabetes	
Drug Abuse/Abuso de Drogas	
Emotional Problems/ Problemas Emocionales	
Epilepsy/Seizures/Fits Epilepsia/Ataques	
Excessive Bleeding or Bruising/ Sangrado o Moretones Excesivos	
Family Violence and/or Child Abuse Violencia Familiar o Abuso Infantil	
Heart Disease/Enfermedad del Corazón	
Heart Attack or Stroke under age 55 yrs Ataque al Corazón o Emolia antes de los 55 años	
High Blood Pressure/Alta Presión	
High Cholesterol and/or Triglycerides Colesterol Alto y/o Triglicéridos	
Sickle Cell Disease/ Anemia de Glóbulus Faláformes	
Other/Otro	

Crept/Crawled/ Arrastró/Gateó _____ months/ meses

Walked alone/ Camió solo _____ months/ meses

Does anyone in the home smoke? Yes/Si No

¿Alguien en la familia fuma?

Is this child often around a smoker? Yes/Si No

¿Este niño esta frecuentemente cerca de un fumador?

Does your water have fluoride? Yes/Si No

¿Su agua tiena fluoruro?

Unknown/No Sabe

BIRTH HISTORY / ANTECEDENTES DEL NACIMIENTO

Pregnancy # _____ of _____ total

(Child # _____ of twins or triplets or _____)

Es el embarazo # _____ de _____ en total

(Es el niño # _____ de cuates o trillizos o _____)

Mother's problems/illnesses during pregnancy:

Enfermedades/problemas de la madre durante el embarazo:

Full Term/ Tiempo Completo

Premature/ Prematuro _____ weeks/ semanas

Normal Delivery C-section Breech

Parto Normal

Cesárea

Nalgas

Hospital _____

Birth Weight/ Peso al Nacer _____ lbs _____ ozs

Length/ Longitud _____ inches

Apgar Scores/ Puntaje de Apgar _____/_____

Blood Type/ Tipo de Sangre _____

In Hospital/ En el Hospital _____ days/ días

Circumcised?/ ¿Circuncidado? Yes/Si No

Complications?/ ¿Complicaciones? Yes/Si No

FEEDING HISTORY / ANTECEDENTES ALIMENTICIOS

Breast Fed Every _____ hours for _____ minutes

Se Amamantó

Cada _____ horas por _____ minutos

Formula Name _____

Nombre de la Leche en Polvo

_____ ounces every/ onzas cada _____ hours/ horas

Frequent formula changes? Yes/Si No

¿Hubo cambios frecuentes en la leche?

Whole milk given at _____ months _____ ozs per day

Se le dio leche entera a los _____ meses _____ ozs por día

Milk used: whole 2% 1% 1/2% skim/

Leche usada: entera _____ descremada

Foods added at _____ months

Se agregaron alimentos a los _____ meses

Appetite: Good Fair Poor Picky

Apetito: Bueno Regular Pobre Quisquilloso

Likes: meats/ carnes vegetables/ verduras

Gustos: fruits/ frutas cereals/ cereales

Rejects: meats/ carnes vegetables/ verduras

Rechazos: fruits/ frutas cereals/ cereales

DEVELOPMENT / DESARROLLO

Rollled over/ Se volteó solo _____ months/ meses

Sat alone/ Se sentó solo _____ months/ meses

Clear words/ Palabras claras _____ months/ meses

Sentences/ Oraciones _____ months/ meses

Dry at night/ Seco de noche _____ months/ meses

Grade in school/ Año escolar _____

School performance: Good Fair Poor

Desempeño escolar: Bueno Regular Pobre

Child's Name / Nombre del niño(a) _____ Today's Date/ Fecha ____/____/____

CHILDHOOD ILLNESSES (CHICKENPOX, EAR INFECTIONS, ETC.)
ENFERMEDADES DE LA NIÑEZ (VARICELA, INFECCIONES DE LOS OÍDOS, ETC.)

Month / Year Mes / Año	Age Edad	What? ¿Qué?

HOSPITALIZATIONS & SURGERIES
HOSPITALIZACIONES Y CIRUGIAS

Hospital	Month / Year Mes / Año	Age Edad	Reason Razón

ACCIDENTS & INJURIES (BROKEN BONES, STITCHES, ETC.)
ACCIDENTES Y LESIONES (HUESOS QUEBRADOS, PUNTADAS, ETC.)

Month / Year Mes / Año	Age Edad	What Happened? ¿Qué Paso?

MEDICINE OR DRUG ALLERGIES
ALERGIAS A MEDICAMENTOS

Drug Medicamento	Age Edad	What Happened? ¿Qué Paso?

OTHER ALLERGIES (ANIMALS, PLANTS, HAY FEVER, ETC.)
OTRAS ALERGIAS (ANIMALES, PLANTAS, FIEBRE DEL HENO, ETC.)

Allergic to: Alérgico a:	Age Edad	Skin Tested: ¿Se hizo prueba en la piel?	What happened? ¿Qué Paso?
		<input type="checkbox"/> Yes/Si <input type="checkbox"/> No	
		<input type="checkbox"/> Yes/Si <input type="checkbox"/> No	
		<input type="checkbox"/> Yes/Si <input type="checkbox"/> No	
		<input type="checkbox"/> Yes/Si <input type="checkbox"/> No	

DOES THIS CHILD TAKE ANY MEDICINES FREQUENTLY?
¿ESTE NIÑO/NIÑA TOMA MEDICAMENTOS FRECUENTEMENTE?

Medicine Medicina	Started Empezó	How Often? ¿Qué Tan Seguido?	Why? ¿Por Qué?

AUTHORIZATION FOR RELEASE OF INFORMATION
AUTORIZACIÓN PARA EL LANZAMIENTO DE LA INFORMACIÓN

I hereby authorize:/ Autorizo:

(Previous Providers or Clinics, Health Dept. / Doctores Anteriores o Clinicas, Departamento de Salud)

Address (include City/State)/ Dirección _____

Phone/ Teléfono _____ **Fax** _____

to release information to:/ que le de información a:

PREMIER PEDIATRICS
705 E. Marshall Ave., Suite 1002
Longview, TX 75601
(903) 247-7700 • Fax (903) 238-9185

Patient Name (Please Print)/ Nombre del paciente

Social Security #/ Número de Seguridad Social

Date/ Fecha

Date of Birth/ Fecha de Nacimiento

Information to be released:/ Información que se puede recibir:

___ **Initial Examination/ Examinación inicial**

___ **Discharge Summary/ Resumen de la Descarga**

___ **Follow-up Care Progress Notes/ Notas de progreso**

___ **Office Visit Notes/ Notas de la Oficina**

___ **Special Procedure Results/ Notas de Procedimientos**

___ **ALL RECORDS/ TODO EL EXPEDIENTE**

The above information is released for the following purpose and that purpose only. Any other use is forbidden: ESTABLISH CARE WITH PREMIER PEDIATRICS.

La información antedicha se lanza para el propósito siguiente y ese propósito solamente. Se prohíbe cualquier otro uso: ESTABLEZCA EL CUIDADO CON PREMIER PEDIATRICS.

ALL RECORDS include any and all medical records regarding my treatment, hospitalization and/or outpatient care for my condition including, but not limited to, psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), AID's related complex (ARC), and HIV antibody testing.

This authorization will expire thirty (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:

Esta autorización expirará treinta (30) días a partir de la fecha de mi firma o según lo especificado de otra manera por la fecha, acontecimiento, o condicione como sigue:

Signature of Parent or Authorized Legal Representative/ Firma

Date/ Fecha

Relationship to Patient/ Relación al paciente

Witness Signature/ Testigo

Premier Pediatrics FINANCIAL POLICY

Thank you for choosing Premier Pediatrics as your health care provider. A patient information sheet and current insurance information is required before seeing the provider. It is your responsibility to inform our office of any changes involving these documents.

The following are our requirements for payment of medical services:

Regarding Fee for Service Patients

We require payment in full for services provided to patients with no insurance. Payment may be made by cash, check, money order, or credit card (Visa/MasterCard).

Regarding Financial Arrangements

We understand that sometimes medical costs can be high and/or the funds are not readily available and payment arrangements are necessary. It is our policy that these arrangements be made prior to services being performed. We will have you sign an "agreement" with specified arrangements for payment.

Regarding Insurance

We will accept assignment of benefits from your primary insurance and one other insurance. A copy of your insurance card(s) is required by our office, and any changes must be brought to our office. If your policy has a deductible or patient responsibility co-pay, then you will be required to make that payment at the time of service unless prior arrangements have been made. **Failure to provide our office with current insurance information that leads to non-payment from the insurance company will result in the balance being transferred to patient responsibility.**

Regarding Non-Covered Services

Please be aware that Medicaid and some insurance companies consider certain services as non-covered services, therefore, you will be expected to pay for these services.

Regarding Insurance Plans Where We Are A Participating Provider

All co-pays and deductibles are due prior to treatment.

Regarding Past Due Patient-Responsibility Account Balances

If no payment has been made on the patient-responsibility balance within 180 days, we will charge interest on that balance at a rate of 7%, compounded annually, beginning with the 181st day.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area.

I have read and agree to abide by the terms of this financial policy.

Signature of Parent/Responsible Party

Date

Premier Pediatrics
705 E. Marshall Ave., Suite 1002
Longview, TX 75601

AUTHORIZATION FOR TREATMENT

Medical care is a patient care service provided in response to a wide range of medical care needs of all ages regardless of gender, color, race, creed, national origin, or disability five days a week at Premier Pediatrics.

The purpose of medical care is:

- To treat disease, injury, and disability by examination, testing, and use of procedures in the aid of diagnosis and treatment.
- To obtain information needed in diagnosing and examining patients.
- To prevent or minimize residual physical and mental disability.
- To aid patients in achieving their maximum potential within their capabilities.
- To accelerate convalescence and reduce the length of functional recovery.

All the procedures will be thoroughly explained to you before they are performed. You are not expected to experience any increase in your current level of pain or discomfort. You should stop any procedure before you experience any increase in your current level of pain or discomfort.

This facility has on staff a Physician Assistant and Nurse Practitioner. Both have received advanced training and education in the provision of health care. Both can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

Based on this information, I agree to cooperate fully, to participate in all medical care procedures, and to comply with the plan of care as it is established. I hereby consent to the services of a physician or mid-level (physician assistant /nurse practitioner). I also understand that at any time I can request to see a physician rather than a mid-level provider.

For your personal safety, do not use any equipment or enter the laboratory area without permission.

I acknowledge that I have read and received copies of the Authorization for Treatment and Patient's Rights and Responsibilities.

Patient Name

Date

Patient/Parent Signature

Witness

Premier Pediatrics

705 E. Marshall Ave., Suite 1002

Longview, TX 75601

ACKNOWLEDGEMENT OF PRIVACY PRACTICES
RECONOCIMIENTO DE LAS PRÁCTICAS DE LA AISLAMIENTO

I, _____ **acknowledge that**
Yo _____ **reconozca que he**
(Name of Guardian/ Nombre del Guarda)

I have read and understand the Notice of Privacy Practices as given
leído y entiendo el aviso de las prácticas de la aislamiento dado

to me this _____ day of _____, 20__.
a mí este (Day/ Día) día de (Month/ Mes) (Year/ Año)

Signature/ Firma _____

Printed Name/ Nombre _____

Witness/ Testigo _____

Patient Name/ Nombre del Paciente _____

Social Security Number/ Número de Seguridad Social _____

PREMIER PEDIATRICS

Providing Care From Birth Through Adolescence



Dear Valued Parent,

We would like to inform you of our policy concerning well child appointments. Due to recurring delays, extra paper work, and time constraints, we ask that you check in fifteen (15) minutes (per child) prior to your scheduled appointment time. If you are unable to arrive early, we will assist you in rescheduling your appointment. Your cooperation with this policy will allow us to give your family quality care in a timely manner. Thank you for your assistance.

Please bring your child's shot record with you to each visit and we will keep it up-to-date. If you lose the shot record and require a replacement, there will be a nominal charge at the time of replacement. Thank you for your consideration.

Sincerely,

Samantha Chaikin, DO
KAE McCrory, DO
Mynda Waldrop, MD
Michelle McCaskill, PA-C
Genie Bartlett, RN, FNP-C

Signature of Parent or Legal Guardian

Date

PREMIER PEDIATRICS

Providing Care From Birth Through Adolescence



HOW DID YOU HEAR ABOUT OUR CLINIC?

Welcome to our clinic! We are so happy to have you and your child(ren) as a patient. To help us out, please let us know how you heard about us:

- Newspaper
- Neighbor/Friend, if so who? _____
- Yellow Pages
- Doctor's Office, if so which one? _____
- Other _____

Thank you,
Premier Pediatrics

TEXAS VACCINES FOR CHILDREN PROGRAM / PROGRAMA DE TEXAS DE VACUNAS PARA NIÑOS

Patient Eligibility Screening • Consent For Tracking

Información Sobre la Elegibilidad del Paciente • Consentimiento Para Immtrac

Date / Fecha _____ Clinic Site / Lugar de Clinica _____

Child's Name / Nombre del niño _____ Social Security # _____
Last / Apellido First / Primer Nombre MI / Inicial Número de Seguridad Social

Child's Date of Birth ____/____/____ Sex ____ Race ____ Parent/Guardian _____
Fecha de nacimiento del niño Sexo Raza Padre/Tutor legal de la persona vacunada

The above-named child (check ONE category that applies):

El niño nombrado (marque la categoría correspondiente):

- Is enrolled in Medicaid or / Recibe beneficios por Medicaid o**
- Does not have health insurance or / No tiene seguro de salud o**
- Is an American Indian or Alaskan Native or / Pertenece a una tribu indigena de los Estados Unido o pertenece a un grupo indigena de Alaska o**
- Is underinsured (has health insurance that does not pay for vaccines) or / Tiene un seguro de salud limitado (su seguro NO paga las vacunas) o**
- Has health insurance that pays for vaccines or/ Tiene seguro que paga para vacunas o**
- Is enrolled in the Children's Health Insurance Program (CHIP) or / Recibe beneficios por Children's Health Insurance Program (CHIP) o**
- Is a patient who is served by any type of public health clinic and does not meet any of the above criteria / Es un paciente que se atiende en clinicas de salud pública y no está incluido en ninguna de las categorías anteriores**

1. I authorize the placement of my child's demographic information and immunization record into the Texas Department of Health's Immunization Registry.

Autorizo que la información demográfica y el récord de inmunizaciones de mi hijo/hija se pongan en el Registro de Inmunizaciones del Departamento de Salud de Texas.

2. I authorize the Texas Department of Health's Immunization Registry 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, local health department, physician to the child, school in which the child is enrolled, and/or child care facility in which the child is enrolled.

Autorizo al Registro de Inmunizaciones del Departamento de Salud de Texas para que disemine cualquier información pasada, presente, y futura en los sobre las inmunizaciones de mi hijo/hija a mí o a cualquiera de las siguientes personas o agencias: distrito de salud pública, departamento de salud local, médico del niño/niña, escuela en que está inscrito el niño/niña, guardería en que está inscrito el niño/niña.

3. I understand that I may withdraw the consent to place information on my child in the immunization registry and my consent to release information from the registry at any time by written communication to the Texas Department of Health, Immunization Registry, 1100 W. 49th Street, Austin TX 78756.

Entiendo que puedo retirar mi autorización para poner la información sobre mi hijo/hija en el registro de inmunizaciones, y que puedo retirar mi autorización para deseminan información del registro en cualquier momento escribiendo al Texas Department of Health, Immunization Registry, 1100 W. 49th Street, Austin TX 78756.

Yes. Add my child's information into the Texas Department of Health's Immunization Registry.
Sí. Ponga la información de mi hijo/hija en el Registro de Inmunizaciones del Departamento de Salud de Texas.

No. Do not add my child's information into the Texas Department of Health's Immunization Registry.
No. No ponga la información de mi hijo/hija en el Registro de Inmunizaciones del Departamento de Salud de Texas.

Parent/Guardian Signature

Firma del padre/del guarda

