



P
A
T
I
E
N
T

Child's Full Name _____

Address _____

City _____ State _____ Zip _____

Telephone # Where Child Lives _____ Other _____

Sex M F Date of Birth ____/____/____ SSN# _____ - _____ - _____

Who Referred Patient? _____

Have you arranged for your child's records to be transferred here from another pediatrician? YES NO

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: ____/____/____

M
O
T
H
E
R

Mother's Full Name _____ Date of Birth _____

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

Mother's Employer: _____

Mother's Home Telephone # _____ Work _____

Cell Phone # _____ SSN# _____ - _____ - _____

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

F
A
T
H
E
R

Father's Full Name _____ Date of Birth _____

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

Father's Employer: _____

Father's Home Telephone # _____ Work _____

Cell Phone # _____ SSN# _____ - _____ - _____

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

E
M
E
R
G
E
N
C
Y

Name of Person NOT Living with Child _____

Home Address _____

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

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# _____ - _____ - _____

I
N
S
U
R
A
N
C
E

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

Name of Child

Date

X _____
Signature of Parent or Guardian

P A S T M E D I C A L H I S T O R Y

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, Reactive Airways Disease, Emphysema)		
IMMUNOLOGIC (Receivnig Chemotherapy or Steroids, AIDS)		
HEART (Heart Disease, Stroke, High Blood Pressure, High Cholesterol)		
BLOOD DISORDERS (Anemia, Sickle Cell Disease, Hemophilia, Leukemia)		
STOMACH (Ulcers, Pyloric Stenosis, Liver Disease, Diarrhea, Constipation)		
KIDNEY (Urinary Tract Infections, Renal Failure)		
ENDOCRINE (Thyroid Disease, Diabetes)		
BONE/MUSCLE (Dislocated Hips, Arthritis, Scoliosis)		
NERVOUS (Headaches, Seizures, Learning Problems, Mental Illness, Mental Retardation)		
OTHER (Cancer, Obesity, Cystic Fibrosis, Birth Defects, Alcoholism)		



CONSENT TO TREAT

I give my consent for diagnosis and treatment to Collin County 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 in each exam room. Your child's digital photograph may be taken and incorporated into the electronic medical record.

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.

ASSIGNMENT OF BENEFITS

I hereby assign Collin County Pediatrics all right, title, and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to Collin County 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 Collin County 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



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 Collin 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