NORTHWEST PEDIATRIC CLINIC

PATIENT INFORMATION

PLEASE PRINT CLEARLY

PATIENT NAME	SEX	DATE OF BIRTH
PATIENT ADDRESS	PATIENT SOCIAL SECURITY NUMBER	
CITY, STATE, ZIP	HOME PHONE	

PARENT INFORMATION

MOTHER'S COMPLETE NAME	DATE OF BIRTH	FATHER'S COMPLETE NAME	DATE OF BIRTH
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
HOME PHONE		HOME PHONE	
CELL PHONE		CELL PHONE	
PHARMACY NUMBER		PHARMACY NUMBER	
EMAIL ADDRESS			

INSURANCE INFORMATION (PERSON WHO APPLIED FOR INSURANCE)

SUBSCRIBER(NAME OF INSURED)	SUBSCRIBER SOCIAL SECURITY #	NAME OF INSURANCE
RELATION TO PATIENT	EMPLOYER	INSRUANCE ID NUMBER/ POLICY NUMBER
SUBSCRIBER DRIVE'S LICENSE	OCCUPATION	MEMBER SERVICE PHONE NUMBER

EMERGENCY CONTACTS

NAME	NAME
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT
HOME TELEPHONE	HOME TELEPHONE
CELL PHONE	CELL PHONE

MAY WE LEAVE MESSAGES WITH THESE CONTACTS REGARDING THIS PATIENT'S MEDICAL INFORMATION/ APPOINTMENT? CHECK _____ YES OR _____ NO

_____ _____

SIGNATURE OF PARENT/GARUDIAN DATE

Pediatric History Form

Northwest Pediatric Clinic
4560 FM 1960 West, Suite 101
Houston, Texas 77069
281-444-0000

Child's Name: _____ Date of Birth: _____

Place of Birth (city/state/hospital): _____

Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

Household

Please list all those living in home.

Name	Relationship	Date of Birth

If mom and dad do not live together or the child doesn't live with them, what's the child's custody status?

_____

Birth History

1. Birth Weight: _____
2. Was the baby born at term: ____ Early: _____
   Late: _____
   If early, how many weeks gestation:
   _____
3. Did the mother have any complications with this pregnancy: Yes _____ No _____
   Explain: _____
4. During pregnancy, did mother: Smoke: Yes___ No___
   Drink: Yes___ No___
   Use Drugs: Yes___ No___
5. Was Delivery: Vaginal _____ Cesarean _____
   If cesarean, why: _____
6. Did baby have any problems after birth: _____
   _____
7. Was initial feeding: Breast _____ Bottle _____
8. Did baby go home with mother from the hospital:
   Yes _____ No _____
   If no, Explain: _____

General

1. Do you think your child to be in good health: Yes___ No___ Explain_____
2. Has your child had any surgeries: Yes___ No___ Explain_____
3. Is your child allergic to any medicines: Yes___ No___ Explain_____
4. Has your child ever been hospitalized: Yes___ No___ Explain_____

Pediatric History Form – Page 2

Patient Name: _____ DOB: _____

5. Has your child had serious illness or accidents: Yes___ No___ Explain_____

6. Are you concerned about your child's mental/emotional health: Yes___ No___ Explain_____

Family History

Have any family members had any of the following

Deafness	Yes___ No___	Bleeding Disorder	Yes___ No___
Nasal Allergies	Yes___ No___	Liver Disease	Yes___ No___
Asthma	Yes___ No___	Kidney Disease	Yes___ No___
Tuberculosis	Yes___ No___	Diabetes	Yes___ No___
Heart Problems	Yes___ No___	Alcohol Abuse	Yes___ No___
High Blood Pressure	Yes___ No___	Drug Abuse	Yes___ No___
High Cholesterol	Yes___ No___	HIV, Aids	Yes___ No___
Anemia	Yes___ No___	Additional Family History	Yes___ No___

Patient's History

Chickenpox	Yes___ No___	Kidney Infection	Yes___ No___
Frequent Ear Infections	Yes___ No___	(Girls) Has She Started Her Menses	
Hearing Problems	Yes___ No___		Yes___ No___
Nasal Allergies	Yes___ No___	(Girls) Are There Problems With Her Menses	
Asthma, Bronchitis, Pneumonia	Yes___ No___		Yes___ No___
Heart Disease	Yes___ No_	Skin Problems	Yes___ No___
Anemia or Blood Problems	Yes___ No___	Headaches	Yes___ No___
Blood Transfusion	Yes___ No___	Diabetes	Yes___ No___
Abdomial Pain	Yes___ No___	Thyroids	Yes___ No___
Use of Alcohol or Drugs	Yes___ No___		

Doctor's Additional Comments

_____

_____

_____

_____ _____

Parent Signature Date Physicians Signature Date

Northwest Pediatric Clinic
4560 FM 1960 West, Suite 101
Houston, TX 77069
Phone: 281-444-0000 Fax: 281-444-6158

POLICIES AND PROCEDURES

Thank you for choosing Northwest Pediatric Clinic for your children's need. At Northwest Pediatric Clinic we pride ourselves on providing quality healthcare and easy accessibility. We welcome you to our practice!

The Clinic sees patients by appointment. We recognize that at times, patients will have urgent needs. We will do our best to provide care for your child during those times, but we encourage all patients to phone the office for a scheduled appointment time. This allows us to provide care in a timely manner to you.

We ask that prior to your appointment you make sure that Dr. Thrity Desai or Dr. Eliza Trevino-Beene are listed as your Primary Care Physician (PCP) on your insurance policy or Medicaid managed care plan. If this is done prior to your appointment, it makes the check-in process much faster. Your insurance company can assist you with this.

We ask that if make an appointment you arrive on time. We only give you fifteen (15) minutes from your appointment time. After that you will have to reschedule for another available day. We do not work-in checkup appointments. Checkups take more time and the appointment time must be kept or rescheduled.

If you make an appointment but can not keep it, please notify us prior to your appointment time. If you fail to do so, it will be considered a "no show." We only allow three (3) "no shows." After that we will notify you and your insurance company in writing of your child's disenrollment. The purpose of this policy is to decrease the number of missed appointments or "no shows" at the clinic. This will allow the staff to more appropriately manage daily schedules, thereby increasing overall productivity.

At Northwest Pediatric Clinic, we want to provide you with a clean and friendly enviroment. We ask that you do not eat or drink in the clinic. We also wish to maintain a wholesome enviroment for the children. In order to do this we ask the noise level be kept to a minimum and no harsh words or profanity be used in the clinic.

Thank you for your cooperation and WELCOME to our practice !!!!

Signature: _____ Date: _____

CONSENT / AUTHORIZATION FOR TREATMENT

I consent to services, treatment and diagnostic procedures, including but not limited to medications, lab tests and other studies, which may be ordered by my physician and consultants as selected by my physician at Northwest Pediatric Clinic.

I acknowledge full responsibility for the payment of such services and agree to pay my bills in full **AT THE TIME OF SERVICE** unless other arrangements are made with the finance department. By signing this consent I assign all rights, title and interest and authorize direct payment to Northwest Pediatric Clinic of any insurance benefits under the Social Security Act for the services. The Northwest Pediatric Clinic will assist in billing my insurance company but I am financially responsible for charges not collected by this assignment, I authorize Northwest Pediatric Clinic to bill my insurance or third party payer and receive payment from them directly.

I acknowledge that to the extent necessary to determine liability for payment or obtain reimbursement, Northwest Pediatric Clinic may disclose my record to any person, Social Security Administration, insurance or benefit payer, health care service or plan, or worker's compensation carrier which is, or may be, liable for all or any of the charges.

I have reviewed the posted Notice of Privacy Practices, which explains how medical information may be used & disclosed. I understand that I am entitled to receive a copy of this document if so desired.

My signature acknowledges that I have given the right to ask questions and receive information about the services and privacy practices and I voluntarily sign this consent. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signed: _____ Date: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____

Northwest PEDIATRIC CLINIC
4560 FM 1960 WEST, SUITE 101
HOUSTON, TEXAS 77069
281-444-0000

CONSENT TO TREAT AND AUTHORIZATION FOR INFORMATION

If I am unable to bring my child to his/her doctor visit(s) **(SOMEONE OTHER THAN PARENTS)**,

Please allow _____, _____
Name of person bringing child **Relationship to patient**

To bring him/her _____, _____
Name of patient **Date of birth**

By my signature below, I grant the above person permission to make any and all medical decisions necessary for my child at the time of visit.

___ Just this visit

___ Anytime I am unable

Please allow _____, _____
Name of person **Relationship to patient**

to get personal information on my child. **(SOMEONE OTHER THAN PARENTS)**

_____ _____
Signature of Parent/Guardian **Date**

This consent will expire one (1) year from the above date.

Texas Vaccines For Children (TVFC) Program
Patient Eligibility Screening Record

A screening record of all children 18 years of age or younger who receive immunizations through the TVFC Program must be kept in the health-care provider's office. The record may be completed by the parent, guardian, or individual of record or by the healthcare provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name:____
   Last Name First Name MI

2. Child's Date of Birth:____________________
   mm/dd/yyyy

3. Parent/Guardian/Individual of Record:______________________________
   Last Name First Name MI

4. Provider's/Clinic's Name: **NW Pediatric Clinic**

5. To determine if a child (0 through 18 years of age) is eligible to receive state or federal vaccine through the TVFC Program, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for TVFC Program.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
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**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

***Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are eligible for vaccines through the TVFC program as long as the provider bills CHIP for the administration of the vaccine.*

**** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

TEXAS
Department of
State Health Services

Texas Vaccines For Children (TVFC) Program
Patient Eligibility Screening Record

(Continued)

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
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Medicaid:

Medicaid Number: ______________________________

Date of Eligibility: ______________________________

CHIP:

CHIP Number: ______________________________

Group Number: ______________________________

Date of Eligibility: ____________________________

Private Insurance:

Name of Insurer: ____________________________

Insurance Name: ____________________________

Insurer Contact Number: ______________________

Policy/Subscriber Number: ____________________

TEXAS Department of State Health Services