NORTHWEST PEDIATRIC CLINIC

PATEINT INFORMATION

PATIENT FULL NAME	SEX	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY	
CITY, STATE, ZIP	HOME TELEPHONE	

PARENTS INFORMATION

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

EMERGENCY CONTACT

NAME
RELATIONSHIP
HOME TELEPHONE
CELL PHONE

SIGNATURE OF PARENT/GUARDIAN

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: _____

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 Cypress Creek Parkway Ste. 101
Houston, TX 77069
Phone: 281-444-0000 Fax: 281-444-6158

I _____ am giving permission to Northwest Pediatric Clinic to give my child _____ his/or her immunizations until my child is 18 years of age. The physician/ NP has described the risks and benefits associated with the immunization(s) scheduled. In addition, I have read the information sheet(s) about the immunization(s) to be given today. I have a chance to ask, questions, which are answered to my satisfaction. I am requesting that the immunization(s) be given to the person for whom I am authorized to make this request.

_____ _____

Signature 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: ____

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

Stock No. C-10
03/2014

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: ____________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____
Last Name First Middle Int. Date of Birth

Street Address: _____
Current Address City State Zip

I hereby request: _____
Name of Clinic, Hospital, other

_____
Address of Clinic, Hospital, other

_____
Phone Number Fax Number

To furnish a copy of **MEDICAL RECORDS** for the above-named patient to:

NORTHWEST PEDIATRIC CLINIC
4560 FM 1960 WEST, SUITE 101
HOUSTON, TEXAS 77069
PHONE: 281-444-0000
FAX: 281-444-6158

For the period of: _____
Begin Date End Date

Purpose of Release: _____

_____ I authorize the release of my complete medical records.
_____ If applicable to my treatment I understand my medical record will contain information regarding the following treatment or testing, authorized by my signature below.
_____ I authorize the release of my HIV/AIDS status and testing.
_____ I authorize the release of information regarding drug and alcohol abuse.
_____ I authorize the release of information regarding psychological disorders.
_____ I authorize the release of diagnostic imaging/x-ray results.
_____ I authorize the release of my medical record to include only the following: _____.

_____

I hereby release your physicians and employees from liability associated with release of this information. I understand this information has been disclosed to me from records whose confidentiality is protected by ***Federal Law.*** *I understand that Federal regulations prohibit me from making any further disclosure of this information except with specific written consent of the patient.*

Signature: _____
Patient, Parent or Guardian if minor, or Legal Representative Date

Relationship to patient: _____

This authorization will expire 90 days from the date of my signature.

Office use only

Requests/Records Sent by: _____ Date: _____