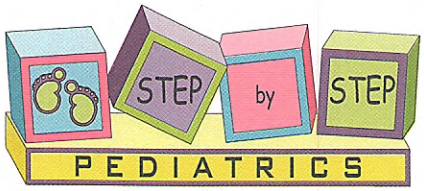


Patient Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____ SS#: _____

Referred by: _____

DEMOGRAPHIC INFORMATION

Father's Name: _____ Date of Birth: _____

SS#: _____ Driver License # _____ State: _____ Exp: _____

Address: _____ City: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Employer: _____

Mother's Name: _____ Date of Birth: _____

SS#: _____ Driver License # _____ State: _____ Exp: _____

Address: _____ City: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Employer: _____

INSURANCE INFORMATION

Insurance Name: _____

Policy or ID#: _____ Group#: _____

Policy Holder Name: _____ Effective Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

I give Step by Step Pediatrics/Dr. Letisha Sneed permission to provide care to my child as deemed necessary. I also grant permission for the above mentioned to bill my insurance company for services provided and understand that in the event my medical insurance provider (both private and/or Medicaid per the Medicaid guidelines) does not pay for such services I will be held responsible for any unpaid balance including late and collection fees. I have also reviewed a copy of the HIPPA policy, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Parent/Guardian Signature **Date**

LETISHA A. SNEED, MD
540 MADISON OAK DRIVE, SUITE 560 SAN ANTONIO, TEXAS 78258 PH. 210-496-STEP (7843) FAX. 210-496-7855

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 baby born at term? _____Early?_____Late?_____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
____Yes ____No Explain _____

During pregnancy, did mother
Smoke ____Yes ____ No Drink Alcohol ____ Yes ____ No
Use drugs or medications ____ Yes ____ No
What _____When _____

Was the delivery ____ Vaginal? ____Cesarean?
If cesarean, why? _____

Did your baby have any problems right after birth?
____ Yes ____ No Explain _____

Was initial feeding ____ Breast? ____ Bottle?

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 medicine 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? _____

Family History

Have any family members had the following:

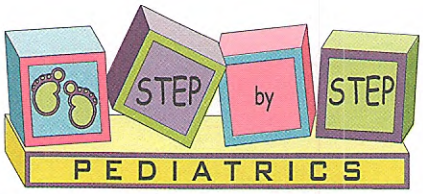
Deafness	___ Yes ___ No	Who _____	Comments _____
Nasal allergies	___ Yes ___ No	Who _____	Comments _____
Asthma	___ Yes ___ No	Who _____	Comments _____
Tuberculosis	___ Yes ___ No	Who _____	Comments _____
Heart disease (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
High blood pressure (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
High cholesterol	___ Yes ___ No	Who _____	Comments _____
Anemia	___ Yes ___ No	Who _____	Comments _____
Bleeding disorder	___ Yes ___ No	Who _____	Comments _____
Liver disease	___ Yes ___ No	Who _____	Comments _____
Kidney disease	___ Yes ___ No	Who _____	Comments _____
Diabetes (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	___ Yes ___ No	Who _____	Comments _____
Epilepsy or convulsions	___ Yes ___ No	Who _____	Comments _____
Alcohol abuse	___ Yes ___ No	Who _____	Comments _____
Drug abuse	___ Yes ___ No	Who _____	Comments _____
Mental illness	___ Yes ___ No	Who _____	Comments _____
Mental retardation	___ Yes ___ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	___ Yes ___ No	Who _____	Comments _____

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	___ Yes ___ No	When _____
Frequent ear infections	___ Yes ___ No	Explain _____
Problems with ears or hearing	___ Yes ___ No	Explain _____
Nasal allergies	___ Yes ___ No	Explain _____
Problems with eyes or vision	___ Yes ___ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	___ Yes ___ No	Explain _____
Any heart problem or heart murmur	___ Yes ___ No	Explain _____
Anemia or bleeding problem	___ Yes ___ No	Explain _____
Blood transfusion	___ Yes ___ No	Explain _____
Frequent abdominal pain	___ Yes ___ No	Explain _____
Constipation requiring doctor visits	___ Yes ___ No	Explain _____
Bladder or kidney infection	___ Yes ___ No	Explain _____
Bed-wetting (after 5 years old)	___ Yes ___ No	Explain _____
(For girls) Has she started her menstrual periods?	___Yes ___ No	When _____
(For girls) Are there problems with her periods?	___ Yes ___ No	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	___ Yes ___ No	Explain _____
Frequent headaches	___ Yes ___ No	Explain _____
Convulsions or other neurologic problems	___ Yes ___ No	Explain _____
Diabetes	___ Yes ___ No	Explain _____
Thyroid or other endocrine problem	___ Yes ___ No	Explain _____
Any other significant problem	___ Yes ___ No	Explain _____
Use of alcohol or drugs	___ Yes ___ No	Explain _____



If your child needs medical, dental or hospital services, a parent must give permission. It's the law. What about times when you cannot be reached for permission? A child needs immediate medical care and that an attempt to obtain parental consent would result in delay which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

You can prepare for unexpected care your children might need when You are away from home. To do this, make sure babysitters know. how to reach you at all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you This is a legal document. With it you may appoint relatives, friends, teachers, clergy, neighbors or anyone who is over 18 years of age to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions when you know it will be hard to contact you.

Fill out this form, give it to the adult(s) you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should be present this document to the appropriate person, physician, dentist or hospital representative.

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Minor(s)	DOB	Allergies/Special Conditions

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name	Address	Phone#

This document shall be presented to a physician, dentist or appropriate hospital representative at such a time as unexpected medical, dental, surgical care or hospitalization may be required.

_____ _____

Signature of Parent / Guardian **Address**

_____ _____

Signature of Parent / Guardian **Address**

_____ _____

Signature of Witness **Address**

Hospitalization Coverage for above Named Minor(s)

Insurance Company or Government Program ID or Contact #

Family Physician:

Name: _____ **Phone:** _____

All articles and any forms, checklist, guidelines and materials are for generalized information only, and should not be reviewed or referred to as primary legal sources nor construed as establishing medical standards of care for the purpose of litigation, including expert testimony. They are intended as resources to be selectively used and always adapted with the advice of the organization's attorney to meet state, local , individual organizations and departments needs or requirements. They are distributed with the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services.

LETISHA A. SNEED, MD
540 MADISON OAK DRIVE, SUITE 560 SAN ANTONIO, TEXAS 78258 PH. 210-496-STEP (7843) FAX. 210-496-7855

REQUEST FOR PATIENT MEDICAL RECORDS

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian Name: _____

Parent/Guardian Contact #: ( ) _____-_____

Parent/Guardian Signature: _____

This document is to serve as a formal request for all medical records for the above listed patient. Please include immunizations, growth charts and medication history. If your office requires payment in advance or you have no record of the patient please contact our office so that we may inform the parent to prevent any delay. We accept medical records in electronic form (CD) or in paper format. All records should be mailed to **Step by Step Pediatrics, 540 Madison Oak Dr., Ste. 560, San Antonio, Texas 78258**, except if records are **10 pages or less**, then fax to **210-496-7855**. If you should have any questions please contact our office at **210-496-7837**. Thank you

Requesting Records From:

Physician/Clinic Name: _____

Address: _____

Phone #: ( ) _____-_____ Fax #: ( ) _____-_____

Expiration Date: _____

Office Use Only

Date Requested: _____ _____ _____

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