Leigh Ann Ware, RN, CPNP, PC
109 North Smith Street - Pleasanton, Texas 78064
Office: 830-281 -8367 Fax: 830-569-8626
www.buildingblockspeds.com
Where God Guides God Provides

INFORMATION

Patient Last Name _____ First Name _____

Date of Birth _____ SS#_____ Sex: ( ) M ( ) F

PATIENT CELL Phone _____

Race: Please check all that apply: __ African American/Black __ American Indian/Alaska Native __ Asian
__ Caucasian/White __ Native Hawaiian/Pacific Islander __ Unknown

Ethnicity: __ Hispanic __ Non-Hispanic **Primary Language**: ___ English ___ Spanish ___ Other (list) _____

****

Mother/Guardian: If Guardian, do you have Power of Attorney of this child? ___N ___Y (please attach copy)

Last Name _____ First Name_____ MI _____

DOB _____ SS# _____ Maiden Name _____

CELL Phone _____ **Email** _____

Mailing address_____ City_____ State_____ Zip Code: _____

Employer Name _____ Phone# _____

****

Father/Guardian: If Guardian, do you have Power of Attorney of this child? ___N ___Y (please attach copy)

Last Name _____ First Name_____ MI _____

DOB _____ SSN# _____

CELL Phone _____ **Email** _____

Mailing address_____ City_____ State_____ Zip Code: _____

Employer Name _____ Phone# _____

****

Primary Insurance _____ Policy Holder _____

ID# _____ Policy Holder DOB _____

Secondary Insurance _____ Policy Holder _____

ID# _____ Policy Holder DOB _____

****

Other Siblings/Immediate family members _____

Preferred Pharmacy _____ Phone_____

Consent of Treatment for Minor Child Information Release:
I, hereby authorize the following listed below to bring my child in for examination and/or treatment or release information either in person or via telephone by Building Blocks Pediatrics.

Name _____ Relation to child _____

Name _____ Relation to child _____

Name _____ Relation to child _____

Authorization of Treatment/Payment
I, hereby authorize Leigh Ann Ware, RN, CPNP, PC dba Building Blocks Pediatrics to provide treatment and services to the names above. I consent to the release of information concerning examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered.

_____ _____
Parent/Legal Guardian Signature Date

Patient Medical History Form

Date	Child's Name	Nickname	DOB	M F

Previous Physician/Office	Request for Records Transfer Complete Y N	Date of Last Physical

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

Birth History

Birth weight _____ Preg # _____ Mom's age _____
Was the baby born on time?_____ Early?_____ Late?_____
If early, how many weeks gestation? _____
Did mother have any illness or problems with her pregnancy? ☐ Y ☐ N
Explain _____

During pregnancy, did mother:
Smoke ☐ Y ☐ N Drink alcohol ☐ Y ☐ N
Use drugs or medications ☐ Y ☐ N
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?
If Cesarean, why? _____
Did your baby have any problems right after birth? ☐ Y ☐ N
Explain _____

Was initial feeding ☐ Breast Milk? ☐ Formula?
Did your baby go home with mother from the hospital? ☐ Y ☐ N
Explain _____

Current and Past History

Is your child currently on any medication? ☐ Y ☐ N Explain _____
Does your child have any serious or chronic illnesses? ☐ Y ☐ N Explain _____
Has your child had serious injuries or accidents? ☐ Y ☐ N Explain _____
Has your child had any surgery? ☐ Y ☐ N Explain _____
Has your child ever been hospitalized? ☐ Y ☐ N Explain _____
Is your child allergic to any medicine or drugs? ☐ Y ☐ N Explain _____
Has your child had any reactions to immunizations? ☐ Y ☐ N Explain _____

Does Your Child Have, or Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia ☐ Y ☐ N Explain _____
Nasal allergies or eczema ☐ Y ☐ N Explain _____
Frequent ear infections or sore throats ☐ Y ☐ N Explain _____
Problems with ears or hearing ☐ Y ☐ N Explain _____
Problems with eyes, vision, or teeth ☐ Y ☐ N Explain _____
Frequent headaches or other neurologic problems ☐ Y ☐ N Explain _____
Frequent abdominal pain ☐ Y ☐ N Explain _____
Constipation requiring doctor visits ☐ Y ☐ N Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old) ☐ Y ☐ N Explain _____
Any heart problem or heart murmur ☐ Y ☐ N Explain _____
Anemia or bleeding problem ☐ Y ☐ N Explain _____
Thyroid or other endocrine problem ☐ Y ☐ N Explain _____
Diabetes ☐ Y ☐ N Explain _____
ADHD ☐ Y ☐ N Explain _____
Mental health issues (anxiety, depression) ☐ Y ☐ N Explain _____
Use of alcohol or drugs ☐ Y ☐ N Explain _____

Any other medical or mental health issues/problems _____

Does your child see any specialists? ☐ Y ☐ N If yes, Who?_____
For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, Speech Therapy? ☐ Y ☐ N Explain _____

Is your child in special or resource classes in school? ☐ Y ☐ N Explain _____

Do you have any other issues or concerns not listed above? _____

See Back

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Child Care: _____

Smokers in household? ☐ Y ☐ N Pets in household? ☐ Y ☐ N

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? _____

_____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had The following:

Alcohol/Drug Abuse	☐ Y ☐ N	Who_____	Comments_____
Allergies	☐ Y ☐ N	Who_____	Comments_____
Anesthesia Risk	☐ Y ☐ N	Who_____	Comments_____
Arthritis	☐ Y ☐ N	Who_____	Comments_____
Blood Disease	☐ Y ☐ N	Who_____	Comments_____
Cancer	☐ Y ☐ N	Who_____	Comments_____
Diabetes	☐ Y ☐ N	Who_____	Comments_____
Genetic	☐ Y ☐ N	Who_____	Comments_____
Gastroenteritis	☐ Y ☐ N	Who_____	Comments_____
Genitourinary	☐ Y ☐ N	Who_____	Comments_____
Heart	☐ Y ☐ N	Who_____	Comments_____
Hypertension	☐ Y ☐ N	Who_____	Comments_____
Lipids	☐ Y ☐ N	Who_____	Comments_____
Neurologic Diagnosis	☐ Y ☐ N	Who_____	Comments_____
Psychiatry	☐ Y ☐ N	Who_____	Comments_____
Ophthalmology	☐ Y ☐ N	Who_____	Comments_____
Respiratory	☐ Y ☐ N	Who_____	Comments_____
Skin	☐ Y ☐ N	Who_____	Comments_____
Stroke	☐ Y ☐ N	Who_____	Comments_____
Thyroid	☐ Y ☐ N	Who_____	Comments_____
Negative Family History	☐ Y ☐ N	Who_____	Comments_____

Additional Family History/Comments _____

_____

_____

Initial Review (initials/date):

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Notice of Text Messaging

If you would like to receive your appointment reminders via text messaging (message rates may apply), rather than phone calls, please indicate below:

___ Text Opt-In ___ Voice Only

Cell-phone # _____

<<Text BBP to 622622 to opt-in NOW>>

Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

I have reviewed this office's Notice of Privacy Practices, which explains how my or my child's medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Notice of Office Policy

- You are required to present your (child's) current insurance card.
- Payments for services are due at time of check-in (Co-pays, co-insurance, cash cases, etc).
- Services requested by patient/guardian/parent that may not be covered under patient's medical insurance coverage (ie: determined not to be reasonable or medically necessary) will be the financial responsibility of the patient/guardian/parent.
- Past Due account(s) must be in regular repayment (arranged with biller and noted in chart) or paid in full prior to scheduling a future appointment. Be prepared to have your child(s) appointment rescheduled or cancelled for failure to keep this obligation if not paid, unless arrangements have been made with billing prior to your child's next appointment.
- Medical records will be released upon written request. If patient account has a PAST DUE balance, it must be paid in full before medical records will be released.
- Medical forms brought in at the time of your appointment or after will be filled out within 10 business days.
- Prescription refill request will be processed no later than 5 working days from the date of request.
- Return to school/work and prescription request after your appointment will be processed within 48 hours from the day you request.
- All missed appointments are noted to the patient chart. After 2 no-shows within a 6 month period, a warning of dismissal letter is issued to the parent/guardian of the patient. After 3 no-shows within a 6-month period, we reserve the right to dismiss a patient from our practice.

Acknowledgment of Review of Notice of Privacy Practices and Office Policies

_____ _____
Printed Name of Patient Signature of Patient (if over 18)

_____ _____
Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

_____ _____
Relation to Patient Date

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Leigh Ann Ware, RN, CPNP, PMHS
Cert Pediatric Nurse Practitioner
Pediatric Mental Health Specialist
Karah Garza, RN, CPNP
Cert Pediatric Nurse Practitioner

Telemedicine Appointments at Building Blocks Pediatrics

Telemedicine/After hours' phone number = **210-871-8292**

What is Telemedicine: *Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the practitioner at the distant site. The Nurse Practitioners at Building Blocks Pediatrics will provide pediatric health care for pre-qualified patients by using Smart Phones with video capability.*

How Does This Happen?

- Patients, who qualify, will need to give a current Cell Phone number when scheduling the appointment.
- Appointments will be scheduled during a specific time slot.
- Parents/Guardians of patients who qualify for **Telemedicine** appointments will receive an "**Invitation**" to accept a secure message prior to their appointment time.
- When this Invitation is received, there are directions to **DOWNLOAD SPRUCE App (this is a FREE app) that you will need to use for the Telemedicine appointment.**
- **Create an account and put your mobile number in, PRIOR TO APPOINTMENT TIME.**

Appointments.
Appointments will be scheduled during a 15-minute window. The Nurse Practitioner will attempt to call you during the allotted time. Please be where you can talk.

Payment.
Telemedicine appointments are "REAL appointments" and you or your insurance will be billed. Credit cards can be used and fee collection will occur at the time the appointment is scheduled.

Required information:
Your Name and Relationship to child**:** _____

List each Child's Full Name	Date of Birth

Signature: _____ **Date:** _____

Cell Phone # _____

Where God Guides God Provides

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Revised 01/2015

Section A: This section must be completed for all Authorization

Patient Name:	Birth Date:	Social Sec. No. (*optional*):

Section B: Records to be released FROM

Physician/Practice/Facility Name:		
Address:		
City	State	Zip
Phone:	Fax:	
Reason(s)/Purpose(s) of disclosure:		

I request the following information:

- ☐ Complete Record
- ☐ Records of Care for the following dates: _____ to _____
- ☐ Other (please specify): _____
- ☐ Confer orally with employees from the named facility about my medical information

I understand that:

1. The medical record may contain copies of information from another healthcare facility or provider
2. I authorized the release of this information to the named party
3. The medical record may contain results of HIV antibody (AIDS) testing, treatment of mental health problems, testing/ treatment of communicable diseases, testing for/treatment of drug or alcohol use
4. I authorize the FAX transmission of the medical records
5. My treatment, payment, enrollment or eligibility for benefits may not be effected on signing this form
6. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
7. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
8. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask

Section C: Records released TO

BUILDING BLOCKS PEDIATRICS
Leigh Ann Ware, RN, CPNP, PC
109 N. Smith Street/PO Box 947
Pleasanton, TX 78064

☐ Leigh Ann Ware

Phone: (830) 281-8367
Fax: (830) 569-8626

Section D: Signatures

I have read the above and authorize the disclosure of the protected health information at stated.

Signature of Patient/Legal Guardian	**Date:**
Print Name of Patient/Legal Guardian	**Relationship to Patient:**

This authorization will expire 180 days from the date I sign this form or at my written request to revoke this authorization