BB Pediatrics PC
dba Building Blocks Pediatrics
109 North Smith Street- Pleasanton, Texas 78064
Office: 830-281 -8367 Fax: 830-569-8626

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 __________________________

Authorization of Treatment/Payment
I, hereby authorize BB Pediatrics, 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

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PATIENT: ______________________________ **DOB:** ________________

Notice of Text Messaging

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

____ Text Opt-In ____ Voice Only

Cell Phone # ______________________________

<<Text BBPEDS 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 child 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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PATIENT: ______________________________ **DOB:** ________________

Social History

1. Please list all current household members and check the relationship to the patient.

Parent: ______________________	O Biological	O Adoptive	O Foster	O Step
Parent: ______________________	O Biological	O Adoptive	O Foster	O Step
Sibling: ______________________	O Biological	O Adoptive	O Foster	O Step
Sibling: ______________________	O Biological	O Adoptive	O Foster	O Step
Sibling: ______________________	O Biological	O Adoptive	O Foster	O Step
Other: ______________________	O Biological	O Adoptive	O Foster	O Step

2. If adopted/foster/step circled above, does this child know? O Yes O No
3. Have there been any major life events in the past year (death, divorce…)? ____________________
4. Do both parents reside at the same address as the patient? O Yes O No
   If both parents do not reside at the same address as the patient…
   - What is the living situation?
     O Joint Custody O Single Custody O Lives with adoptive parents O Lives with foster parents
     O Other: ____________________
   - Name of the parent who does not reside at same address as patient: ____________________
   - Any outside agency involvement (Y/N) ____________________
5. Any pets (kind)? ____________________ Indoors (#) ______ Outdoors (#) ______
6. Is there anything else we should know about your family structure: ____________________
7. Any smokers in the home (Y/N); (indoors / outdoors) ____________________
8. School/Daycare attending: ____________________ Current grade: ________
9. What is it about your child that makes you proud of him/her? ____________________

Birth History (ONLY if new patient is 3yrs and younger; can be skipped if 4yrs and older)

Birth weight ________ Preg# _____ Mom's age _____ Was delivery: O Vaginal? O Cesarean?

Was baby born on time (Y / N) Early? ____ Late? ____ If Cesarean, why? ____________________

If early, how many weeks? ____________________ Did your baby have problems after birth? (Y / N)

Did mother have any problems w/ pregnancy? (Y / N) Explain: ____________________

Explain: ____________________ ____________________

During pregnancy, did mother:

Smoke (Y / N) Drink alcohol (Y / N) Was initial feeding: O Breast Milk O Formula

Use drugs/medications (Y / N) Did your baby go home w/ mother: (Y / N)

What ______________ When ____________________ Explain: ____________________

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PATIENT: ________________________________ **DOB:** ____________________

Current and Past Patient History

Is your child currently on any medications	O Y	O N	Explain________________
Does your child have any serious or chronic illness?	O Y	O N	Explain________________
Has your child had serious injuries or accidents?	O Y	O N	Explain________________
Has your child had any surgery?	O Y	O N	Explain________________
Has your child been hospitalized?	O Y	O N	Explain________________
Is your child allergic to any medicine or drugs?	O Y	O N	Explain________________
Has your child had any reactions to immunizations?	O Y	O N	Explain________________
Does your child have, or ever had:			
Asthma, bronchitis or pneumonia	O Y	O N	Explain________________
Nasal allergies or eczema	O Y	O N	Explain________________
Frequent ear infections or sore throats	O Y	O N	Explain________________
Problems with ears or hearing	O Y	O N	Explain________________
Problems with eyes, vision or teeth	O Y	O N	Explain________________
Frequent headaches or neurologic problems	O Y	O N	Explain________________
Frequent abdominal pain	O Y	O N	Explain________________
Constipation requiring doctor visits	O Y	O N	Explain________________
Bladder/kidney issues or bed-wetting (after 5yr)	O Y	O N	Explain________________
Any heart problem or heart murmur	O Y	O N	Explain________________
Anemia or bleeding problem	O Y	O N	Explain________________
Thyroid or other endocrine problem	O Y	O N	Explain________________
Diabetes	O Y	O N	Explain________________
ADD / ADHD	O Y	O N	Explain________________
Mental health issues (anxiety, depression)	O Y	O N	Explain________________
Use of alcohol or drugs	O Y	O N	Explain________________

Any other medical or mental health issues/problems: ________________________________

____

Does your child see any specialists	O Y	O N	Explain________________

For what reason or diagnosis: ________________________________

Has your child ever received Occupational Therapy, Physical Therapy or Speech Therapy	O Y	O N	Explain________________
Is your child in special or resource classes in school	O Y	O N	Explain________________

Additional issues concerns not listed above: ________________________________

Family Medical History (Parents, Siblings, Grandparents)

Have Any Family Members had the following:

Alcohol/Drug Abuse	O Y	O N	Who__________	Heart	O Y	O N	Who__________
Allergies	O Y	O N	Who__________	Hypertension	O Y	O N	Who__________
Anesthesia Risk	O Y	O N	Who__________	Lipids	O Y	O N	Who__________
Arthritis	O Y	O N	Who__________	Neurologic Disorder	O Y	O N	Who__________
Blood Disease	O Y	O N	Who__________	Psychiatry	O Y	O N	Who__________
Cancer	O Y	O N	Who__________	Ophthalmology	O Y	O N	Who__________
Diabetes	O Y	O N	Who__________	Respiratory	O Y	O N	Who__________
Genetic	O Y	O N	Who__________	Skin	O Y	O N	Who__________
Gastroenteritis	O Y	O N	Who__________	Stroke	O Y	O N	Who__________
Genitourinary	O Y	O N	Who__________	Thyroid	O Y	O N	Who__________

Additional Family History/Comments ________________________________

____

Texas Immunization Registry (ImmTrac2)
Adult Consent Form

First Name ______ Middle Name ______ Last Name ______

___/___/______ Date of Birth (mm/dd/yyyy) Gender: ☐ Male ☐ Female ___-___-____ Telephone ______ Email address

Address ______ Apartment # / Building # ______

City ______ State ______ Zip Code ______ County ______

Mother's First Name ______ Mother's Maiden Name ______

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your immunization records. With your consent, your immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

EntitiesI understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, my immunization information may by law be accessed by: a Texas physician, or other health-care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas Immunization Registry.

Individual (or individual's legally authorized representative):

Printed Name ______ Signature ______ Date ______

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)

Provider Statement

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

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Section A: This section must be completed for all Authorization

Patient Name:	Birth Date:

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, testing or treatment of communicable diseases, treatment of mental health problems, testing for or treatment of drug or alcohol use or abuse
4. I authorize the FAX transmission of the medical records
5. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization
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 for it.

Section C: Send records to

BUILDING BLOCKS PEDIATRICS
109 N. Smith Street
Pleasanton, TX 78064

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	**Relationshiop to Patient:**

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