Richardson Pediatric Associates
Patient Registration

Today's Date: _____

1112 N. Floyd Rd Suite #6A & 7 Richardson, TX 75080 972-952-0280

Patient Information:

Patient's Full Name: _____ DOB: _____ Male ☐ Female ☐
(Last) (First) (M.I.)

Full Address: _____
(City) (State) (Zip)

Allergies/Drug Reactions: _____ Who Referred You: _____

Preferred Pharmacy: _____
(Pharmacy Name) (Street) (City) (Phone Number)

List of Siblings

Name: _____ Male ☐ Female ☐ Date of Birth _____

Name: _____ Male ☐ Female ☐ Date of Birth _____

Name: _____ Male ☐ Female ☐ Date of Birth _____

Name: _____ Male ☐ Female ☐ Date of Birth _____

Father/ Guardian Information - 1

Last, First Name: _____

Date of Birth: _____ Height: _____ Male ☐ Female ☐

SS#: _____

Address: _____

City, State, Zip: _____

Occupation: _____

Email Address: _____

Employer: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Relationship to Patient: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Mother / Guardian Information - 2

Last, First Name: _____ Maiden: _____

Date of Birth: _____ Height: _____ Male ☐ Female ☐

SS#: _____

Address: _____

City, State, Zip: _____

Occupation: _____

Email Address: _____

Employer: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Relationship to Patient: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Primary Insurance Information

☐ United Healthcare ☐ Cigna ☐ Aetna ☐ Blue Cross Blue Shield ☐ Other _____

Insured / Card Holder's Name: _____ Date of Birth _____ SS#: _____

Emergency Contact - OTHER THAN PARENT

Name of Contact: _____ Male ☐ Female ☐

Home Phone: _____ Cell: _____ Work: _____

Relationship to Child: ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Signature (Parent/Guardian)

Date

**Signature here allows messages to be left at the listed numbers above via voicemail, person, etc.*

CHILD'S NAME_____

Last **First** **Date Of Birth**

Who spends most time caring for this child? (mother, father, daycare, etc? _____
In your opinion, is this child generally happy or unhappy? _____
Number of people living in child's home? _____

	YES	NO
BIRTH HISTORY: When you were pregnant with this child did you:		
1). Take medications other than prenatal vitamins?		
2). Have high blood pressure?		
3). Have Diabetes?		
4). Have any other diseases or conditions?		
5). Were there any problems with this pregnancy?		
6). Did you have a difficult delivery?		
7). What was this child's weight at birth?		
8). Was there an Rh or blood problem?		
9). Was there anything wrong with this child at birth?		
10). How many children do you have?		
11). Which one is this child?		
12). Where was this child born? (city & hospital)		
FAMILY HISTORY: Has any of your child's immediate family		
(child's mother & father) ever had any of the following?		
13). Birth Defects		
14). Blood Diseases(leukemia, hemophilia, anemia, etc)		
15). Bone or joint disorders		
16). Cancers or malignancies		
17). Chronic lung disease (asthma, bronchitis)		
18). Eye or ear disorder		
19). Glandular disease (diabetes, thyroid)		
20). Heart Trouble		
21). Early deaths that were unexpected		
22). Kidney or urinary disease		
23). Intellectual disability		
24). Muscle disease (weakness, cerebral palsy)		
25). Psychiatric condition		
26). Learning Disorders		
27). Tuberculosis		
28). Problems with elevated cholesterol		
29). Sexually transmitted disease		
30). Anything else?		

Patient Consent to Treat

I hereby give my consent to Richardson Pediatric Associates and authorize him or her to provide my medical treatment. I understand that Richardson Pediatric Associates will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Richardson Pediatric Associates to perform any additional or different treatment that is thought necessary if, in an emergency, a condition is discovered that was not known previously.

_____

Signature of Patient, Parent, or Guardian

_____

Date

_____

Name of Patient

_____

Your relationship to patient

Acknowledgement of Review of Notice of Privacy Practices

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

_____

Signature of Patient, Parent, or Guardian

_____

Date

_____

Name of Patient

_____

Your relationship to patient

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. @Hotmail, @Gmail, @Yahoo) do not utilize encrypted email
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet.

  In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http:(/www.gpo.gov/fdsvs/pkg/FR-2013-01-25/pdf(2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 - ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Richardson Pediatric Associates to send me personal health information via unencrypted email

_____	_____	_____	_____
Signature (parent or guardian if patient is a minor)	Date	Printed name	Please print email address

OPTION 2 - DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

_____	_____	_____
Signature (parent or guardian if patient is a minor)	Date	Printed name

Authorization for Payment

If I am a member of a health care plan, of which Norah Randles, M.D., Sarah Troendle, M.D., Abbie Smith, M.D., Natalie Pounds, M.D., or Kristen Kammerer, DO., is an authorized provider, I understand that I must present my Health Plan Identification at each visit or I agree to pay the charges billed by my physician at the time of the visit. I understand that I am responsible for all copayments and deductibles under the plan and must pay them at the time of the visit.

In the event I request that my physician provide medical services, lab procedures, or immunizations which are not authorized or covered by my health care plan, I hereby agree, in advance, to pay the physician at his customary billed charges for such services. In the event that my physician does not perform certain in-office lab services in his office for my convenience, I agree to pay the physician at his billed charges since this service is considered to be "out of network."

_____

Signature of Patient, Parent, or Guardian

_____

Date

_____

Name of Patient

_____

Your relationship to patient

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth / / **Children under 18 years only.*

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, 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 (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. 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 ("ImmTrac"). Once in ImmTrac, 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 ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac 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.state.tx.us 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 ImmTrac 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 • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

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