Richardson Pediatric
ASSOCIATES

Patient Information:

Patient's Name (Last, First): _____ DOB: _____ MALE/ FEMALE

Full Address: _____ Zip: _____

Race: _____ Ethnicity: _____ Who Referred You: _____

Preferred Pharmacy: _____ Pharmacy Number: _____

List of Siblings:

Name: _____ M/F DOB: _____

Name: _____ M/F DOB: _____

Name: _____ M/F DOB: _____

Name: _____ M/F DOB: _____

Mother/ Guardian Information:

Last, First Name: _____ Maiden Name: _____

Date of Birth: _____ Height: _____ Marital Status: _____ Male/ Female

SS # _____ Phone Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Employer: _____

E-Mail Address: _____ Relationship to Patient: _____

Father/ Guardian Information:

Last, First Name: _____ Maiden Name: _____

Date of Birth: _____ Height: _____ Marital Status: _____ Male/ Female

SS # _____ Phone Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Employer: _____

E-Mail Address: _____ Relationship to Patient: _____

Emergency Contact (OTHER THAN PARENT)

Name of Contact: _____ Phone Number: _____ Relationship to Child: _____ MALE/FEMALE

Subscriber Insurance Information:

° United Healthcare °Cigna °Aetna °Blue Cross Bue Shield °Other _____

Insured / Card Holder's Name: _____ Cell: _____ SS#: _____

Signature (Parent/ Guardian) _____ **Date:** _____

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Patients Name (Last, First): _____ **Date of Birth:** _____

Allergies/ Drug Reactions: _____

Who spends most of the 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? _____

Birth History: When you were pregnant with this child did you?

1. Take medications other than prenatal vitamins? Y/N
2. Have high blood pressure? Y/N
3. Have diabetes? Y/N
4. Have any other diseases or conditions? Y/N
5. Were there any problems with this pregnancy? Y/N
6. Did you have a difficult delivery? Y/N
7. What was this child's weight at birth? Y/N
8. Was there an Rh or blood problem? Y/N
9. Was there anything wrong with this child at birth? Y/N
10. How many children do you have? Y/N
11. Which one is this child? Y/N
12. Where was this child born? (City & Hospital) Y/N

Family History: Has any of your child's immediate family (child's mother & father) ever had any of the following?

13. Birth defects Y/N
14. Blood Diseases (leukemia, hemophilia, anemia etc.) Y/N
15. Bone or joint disorders Y/N
16. Cancers or malignancies Y/N
17. Chronic lung disease (asthma, bronchitis) Y/N
18. Eye or ear disorder Y/N
19. Glandular disease (diabetes, thyroid) Y/N
20. Heart Trouble Y/N
21. Early deaths that were unexpected Y/N
22. Kidney or urinary disease Y/N
23. Intellectual disability Y/N
24. Muscle disease (weakness, cerebral palsy) Y/N
25. Psychiatric condition Y/N
26. Learning disorders Y/N
27. Tuberculosis Y/N
28. Problems with elevated cholesterol Y/N
29. Sexually transmitted disease Y/N
30. Anything else?

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Childs Name:_____DOB:_____/_____/_____

Financial/General Policies:

- Richardson Pediatric Associates is not responsible for determining if we are on your insurance plan. It is your responsibility to contact your insurance plan for this information.
- All co-pays are due at the time of service.
- If insurance has any changes, please notify our office within 30 days (about 4 and a half weeks).
- There will be a $50 charge if accounts are forwarded to a collection agency and a $50 charge for returned checks.
- There will be a $50 charge for each missed appointment.
- You agree for us to service your account, we may contact you by telephone, email or text with any contact provided to us, including leaving messages.
- Please be prepared to provide ID and insurance card at each visit.
- Payment is expected at time of service, regardless of who brings the child to appointments.
- Richardson Pediatric Associates will only file the primary insurance.
- In the event that any service that is not deemed a covered benefit by your insurance policy, you agree to pay for such services at the customary billed charge.
- Physical assessment will be needed for all prescriptions, referrals and to complete signed forms.
- Late arrivals may need to be rescheduled.
- No medical records will be released without written communication from parent / guardian.
- As medical professionals we feel very strongly that vaccinating children on schedule with current available vaccines is the absolute right thing to do for all children and young adults. If you refuse to vaccinate your child, we ask that you find another health care provider who shares your views.

I have read and agree with the financial / general policies of Richarson Pediatric Associates. I assign insurance benefits to be paid directly to Richardson Pediatric Associates or any provider in the practice. I understand that I am financially responsible for all non-covered services under the terms of my health care coverage. I authorize the release of medical information of the patient(s) to their insurance company for the purpose of filing insurance claims.

Printed Name of Parent / Legal Guardian: _____

Signature of Parent / Legal Guardian: _____Date: _____

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Childs Name:_____DOB:_____/_____/_____

Authorizations:

- I agree to receive automatic phone calls which may include appointments, test results, and more on any devices I have listed, including mobile devices.
- I hereby give consent to Richardson Pediatric Associates and authorize this office to provide medical treatment for my child. I understand that the providers will explain my child's condition(s), unforeseeable risks, and methods of treatment for my child's condition before treatment is provided. I authorize this office to perform any additional or different treatment that is thought necessary if, in an emergency, a condition is discovered that was not previously known.

Printed Name of Parent / Legal Guardian:_____

Signature of Parent / Legal Guardian:_____Date:_____

Notice of Privacy Practices:

I have reviewed the 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 this documentation. This can also be found on the practice website.

Printed Name of Parent / Legal Guardian:_____

Signature of Parent / Legal Guardian:_____Date:_____

Email Authorization:

Richardson Pediatric Associates uses unencrypted email. You understand the risk of unencrypted email and give permission to send health information via this method. If you decline, please write DECLINE.

Printed Name of Parent / Legal Guardian:_____

Signature of Parent / Guardian:_____Date:_____

Email Address:_____

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

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female

Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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. For more information, see Texas Health and Safety Code § 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
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 § 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

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 _____ 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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

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

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

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