915 Gessner, Ste. 985
Houston, TX 77024
713-461-9100

Registration Form

Patient Name: ____________________________________ **Date of Birth** ________________ **SEX (F / M)**
Last First M.I
Home Address: ____ **Apt #** ________________
City: __________________________ **State:** ____________ **Zip Code:** ______________
Primary number: ____________________________ **Secondary number:** ____________________________
Email: ____

Responsible Party/Authorized Individuals for Treatment

Mother's Name: ____ **DOB:** ______________________
Father's Name: ____ **DOB:** ______________________
Other: ____ **Relationship to Patient:** ____________________
Other: ____ **Relationship to Patient:** ____________________

It is a policy of Memorial City Pediatrics that individuals other than parents who are authorized above are able to schedule appointments and consent to medical treatment including lab, vaccines, antibiotic injections and prescriptions

Primary Insurance

Insurance Company: ____________________ **Policy Holder:** _____________________________________
DOB: ________________ **Member ID:** ____________________________ **Group #**_____________________
Does the Patient have Secondary insurance? (Y / N) If yes please list insurance information:
Insurance Company: ____________________ **Policy Holder:** _____________________________________
DOB: ________________ **Member ID:** ____________________________ **Group #**_____________________

Insurance assignment & release of information

- I authorize the release of my child's medical information that is necessary to process insurance claims.
- I authorize the release of payment of medical benefits to my child's provider.
- I have received notice of Memorial City Pediatrics privacy practice policy.
- I have read Memorial City Pediatrics office policy and agree to the terms listed.
- I understand that I am financial responsible for any deductibles & co-insurances fees and charges for non-covered services. Unless I am a member of an insurance organization Memorial City Pediatrics is contracted with, all charges are due at the time services are rendered.

Guarantor's signature_____________________________________ **Date:** _____________________

Medical History

Pregnancy and Birth History

What type of Delivery?
____Vaginal ____ C-Section ____ Vertex ____ Breech _____ Other
How old was the mother at time of delivery? _____________ Gestational weeks: __________________
Birth Weight: ______________ Length: _______________ Hospital: __________________________________
Was your baby born premature? ____ Yes ____ No Did the patient pass the hearing screen? ___Yes ___No
Received Heb B vaccine at birth? ____ Yes ____No
Were any of the maternal labs positive? ___ Yes ____No
Maternal Illness during pregnancy or early labor? ____ Yes ____ No
Any medications, smoking or alcohol used during pregnancy? ____ Yes ____No
(Rubella, HEP B, Syphilis, HIV, Herpes, group B strep, other) If yes, which ones? ________________________________
Did the baby have any complications while in the hospital? ____ Yes ____ No
(Infection, Jaundice, Breathing difficulties, NICU, other) If yes, please list: ____________________________________

Patient Medical History

Has the patient ever had surgery? ____ Yes ____No
If yes, when and the reason? ____
Has the patient ever been hospitalized before? ____ Yes ____No
If yes, why and did the patient stay overnight? ____
Does your child see any specialist? _____ Yes ____ No
Are Immunizations up to date? ____ Yes ____No
Patient taking any medications? ____Yes ____No If Yes, which medications ____________________________
Any Allergies? (Medication, Food, other) ____ Yes ____No
If yes which ones? ____

Check any medical problems your child has or had:
___urinary tract infection ___Vision/Hearing problem ___Emotional/Behavior Problem ___ Pneumonia
___ Developmental Delay ___Allergies ___ Speech problems ___Asthma ___ Frequent Strep throat
___ Anemia ___Seizures ___ Constipation ___Heart Problem ____ school problems ___ Lyme Disease
List any medical problems your child has had that are not listed above: ___________________________________

Family History

Family History - (Please identify family members with a history of medical concerns.)
___AIDS ___Cancer ___Heart Conditions ___ High Blood Pressure ___Blood Disorder ___Diabetes
___ Hepatitis type ___Mental disorder ___ Neurologic Disorder ___ Thyroid Problem ___Tuberculosis
Other: ________________________________
Please list any other significant chronic illnesses in the family: ____
Any cigarette smoking in the house? ____ Yes ____No Was the house built before 1978? ____ Yes ____No
Who does the child live with? ___ both parents ___Mom ___Dad ___Foster care ___Adopted ___Other

Form completed by: _______________________ Signature:____

Telemedicine/COVID Consent form

Patient name:___________________________________

Telemedicine Consent

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telemedicine.
- I understand that I will be responsible for any copayments, coinsurances, deductibles and charges for non-covered services that apply to my telemedicine visit.
- I understand that the purpose of telemedicine is to improve access to medical care by enable a patient to review at their home. I understand that there are possible risks with the use of telemedicine, that's including but not limited to; limited exams, Poor resolution imaging, Failure of the equipment and rarely failure of security protocols causing a breach of privacy of personal medical information.
- I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Parent signature:_______________________________________ Date: _____________________

Covid 19 Informed Consent

- Thank you for your confidence in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection controls to limit transmission of all diseases in our office and continue to do so.

- Despite our careful attention to disinfection, use of personal barriers and practicing social distancing, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurants.

- Although exposure is unlikely, the risk cannot be eliminated completely.
- I am aware of this risk and consent to treatment under current circumstances.

Parent Signature: _________________________________ Date:____________________________

HIPAA Compliance Consent Form

HIPAA (Health Insurance Portability and Accountability Act) Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive

I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure

Consent for Treatment

- I hereby voluntarily consent to care for my child encompassing diagnostic procedures and medical treatment by my physician, her assistants or her designees as may be necessary in her judgment.
- I agree for my child to have HIV and other communicable disease testing in the event of a healthcare worker being exposed to my child's bodily fluids

Immunization consent

I hereby voluntarily consent to vaccinate my child, as per the recommended schedules from the Center for Disease Control (CDC) and the American Academy of Pediatrics (AAP).

By signing this form, I have read and agree to the following consent forms; (HIPAA, CONSENT FOR TREATMENT AND IMMUNIZATION CONSENT)

Parent Signature:___________________________________ Date:_______________________________________