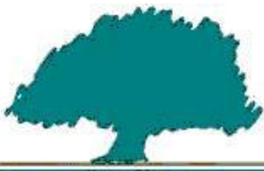


Pediatric Clinic, P.A.

Gerald A. Stagg, MD, FAAP
Joel D. Chapman, MD, FAAP
J. Colton Bradshaw, MD, FAAP
Marc E. Kimball, MD, FAAP

PATIENT

First	Middle	Last	Nickname (if any)	Present Age	Date of Birth
Mailing Address			Social Security #	☐ Male ☐ Female	Caucasian Hispanic Black or African American American Indian Other
City	State	Zip Code	Primary Phone Number		

PARENT/GUARDIAN

Mother's Name		Date of Birth	Primary Phone Home Work Cell
Address (if different)	Social Security #	Driver's License#	Alternate Phone Home Work Cell
	Employer		Email Address
Father's Name		Date of Birth	Primary Phone Home Work Cell
Address (if different)	Social Security #	Driver's License #	Alternate Phone Home Work Cell
	Employer		Email Address
Responsible Party (if parent under 18 years old)		Relationship	Primary Phone Home Work Cell
Address			Alternate Phone Home Work Cell

INSURANCE

Patient's Primary Insurance Company	Name of Insured Party	Insured Date of Birth	Insured Phone
Insured Party Social Security #	Insured ID #	Policy Group #	Relationship to patient
Patient's Secondary Insurance Company	Name of Insured Party	Insured Date of Birth	Insured Phone
Insured Party Social Security #	Insured ID #	Policy Group #	Relationship to patient

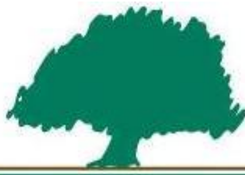
EMERGENCY CONTACTS / SIBLINGS

Emergency Contacts: Name	Phone	Siblings: Name	Date of Birth
Name	Phone	Name	Date of Birth
Name	Phone	Name	Date of Birth
Name	Phone	Name	Date of Birth
Name	Phone	Name	Date of Birth

Signature of Responsible Party ______ Date ______   Update Signature ______ Date ______

Update Signature ______ Date ______   Update Signature ______ Date ______

2001 N. Jefferson Medical Office Building, Suite 300 Mt. Pleasant, Texas 75455 903-572-9823 FAX 903-572-4812



Pediatric Clinic, P.A.

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.

____
Printed Name of Patient

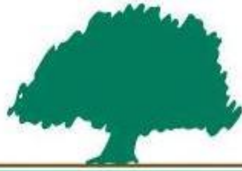
____
Patient's Date of Birth

____
Printed Name of Parent or Guardian

____
Signature of Patient, Parent or Guardian

____
Relationship to Patient

____
Date



Pediatric Clinic, P.A.

PARENTAL CONSENT FOR TREATMENT

In accordance with Texas Law, the Pediatric Clinic will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent.

In Texas, a patient is considered a "minor" if he/she is under 18 years, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for the following child in my absence.

__________________________________ _______________________
Patient/Child Patient/Child Date of Birth

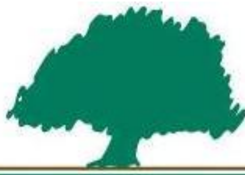
____ _________________
Name/Relationship Phone #

____ _________________
Name/Relationship Phone #

____ _________________
Name/Relationship Phone #

____ _________________
Name/Relationship Phone #

____
Parent/Legal Guardian Date



PATIENT AUTHORIZATION

Patient/Child Name ___________________________Date of Birth_______________

Please initial all applicable boxes. If a category does not apply to you, please write "N/A".

Initials *MEDICAID ASSIGNMENT OF BENEFITS*

☐ I certify that the information I gave in applying for payment of Medicaid benefit is correct. I assign Medicaid benefits payable for Pediatric Clinic, P.A. services to the Pediatric Clinic, P.A.

FINANCIAL RESPONSIBILITY

☐ I will honor the Pediatric Clinic, P.A. payment policy by payment in full at the time services are rendered, unless prior arrangements have been made. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment for services rendered at the Pediatric Clinic, P.A. I am responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that I may be billed for out sourced services (i.e. lab, x-ray, etc.); and I may receive additional billing from another facility. I agree to pay all expenses related to collection, whether by collection agency or by an attorney.

INSURANCE RESPONSIBILITY

☐ I irrevocably assign and transfer to the Pediatric Clinic, P.A. all insurance benefits covering the Pediatric Clinic, P.A. services for the payment of serviced rendered. I understand it is my responsibility for providing a current copy of my insurance card and to comply with all pre-certification requirements.

AUTHORIZATION FOR CARE

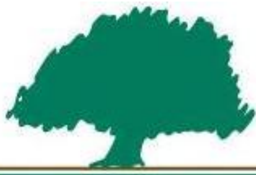
☐ I grant permission for the Pediatric Clinic, P.A. to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ I hereby authorize the Pediatric Clinic, P.A. to release necessary information for the following reasons: to other physicians for continuing professional care; to any insurance company or their representatives; or otherwise as allowed by law. I release the Pediatric Clinic, P.A. from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time.

____ ____________________

Signature of Parent/Legal Guardian Date



NEW PATIENT

To Be Completed By Parent:

Name ______________________________ Birth Date _________ Date First Seen ______
Race _________________ Sex __________ Insurance ____________________________
Hospital born _______________________ Address _____________________________
Obstetrician _________________________ Address _____________________________
Referred by _________________________
Father's Name _______________________ Address _____________________________
Mother's Name ______________________ Address _____________________________

To Be Completed By Nurse: Family History

ALLERGIES

	Age	Health	Food/Enviro.	Type of Allergy
Mother				
Father				
Sibling				
Sibling				

OTHER

Tuberculosis ______ TBC Contacts_____
Diabetes______ Convulsive Disease_____
Mother's Blood Type ______RH_______
Baby's Blood Type _________________

Birth and Development

Term __________________ Delivery ________________ Birth Weight ________________
Condition at Birth _________________________________ Apgar Score ________________
Cyanosis ______________________________Jaundice ______________________________

Feeding History

Breast ________________ Formula ____________________ Vitamins ________________