New Patient Registration

Sprout Pediatrics

PATIENT INFORMATION
Child's full legal name _____
(Last/First/Middle)
Date of Birth _____ **Nickname** _____
Sex ☐ Male ☐ Female **Home Phone** _____
Home Address _____
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian and other Pacific Islander
☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race
Ethnicity: ☐ Hispanic ☐ Nonhispanic **Patient's Primary Language:** ☐ English ☐ Spanish ☐ Other
Parent's.Legal Guardian's Primary Language: ☐ English ☐ Spanish ☐ Other **Translator Needed?** ☐ Yes ☐ No

Other children in family

Name	Date of Birth	Seen at this practice? (yes/no)

MOTHER'S INFORMATION ☐ Guarantor/financially responsible for account
Mother's full legal name _____
(Last/First/Middle)
Date of Birth _____ SSN _____
Driver's License # _____ Cell phone _____
Occupation _____ Employer _____
Employer Address _____
Work phone _____ Email address _____
If different than patient, please enter home address and phone number below
_____

FATHER'S INFORMATION ☐ Guarantor/financially responsible for account
Father's full legal name _____
(Last/First/Middle)
Date of Birth _____ SSN _____
Driver's License # _____ Cell phone _____
Occupation _____ Employer _____
Employer Address _____
Work phone _____ Email address _____
If different than patient, please enter home address and phone number below
_____

Additional Contact Name _____
Relationship to patient _____ Phone _____

Which phone number is your preferred method of contact?
Mom's: ☐ home phone ☐ cell phone ☐ work phone **Dad's:** ☐ home phone ☐ cell phone ☐ work phone
May we leave your child's lab results on your voicemail? ☐ Yes ☐ No

INSURANCE INFORMATION (copy of insurance card and required to file insurance)
Primary insurance carrier name _____
Address _____
Insurance Phone _____ Effective Date _____
Policy Holder Name _____ Group Name _____
Member # _____ Group # _____

How did you hear about us? ☐ Patient at previous practice ☐ Facebook ☐ Website
☐ Personal referral _____ ☐ Other _____

Who is your PCP (primary care physician) in our office? ☐ Dr Dehlavi ☐ Dr White

Pharmacy Name _____ Phone _____

Signature _____ Date_____

Completed by _____ (Clinic Use) 2/7

Medical History

Name: _____ Date of Birth: _____

PATIENT'S BIRTH HISTORY

Mother's prenatal history:

Name of OB _____ Number of pregnancies _____ Number of living children _____

During pregnancy/immediately around the time of delivery, were there any maternal health issues? ☐ Yes ☐ No (*if yes, see below)

During pregnancy, did mother use prenatal vitamins? ☐ Yes ☐ No

During pregnancy, did mother
- take any prescribed medications? ☐ Yes ☐ No (*if yes, see below)
- drink alcohol? ☐ Yes ☐ No (*if yes, see below)
- use tobacco? ☐ Yes ☐ No (*if yes, see below)
- use other drugs? ☐ Yes ☐ No (*if yes, see below)

Please provide details / explain yes answers from above:

_____

Delivery:

Hospital of Birth _____

Type of Birth ☐ VAGINAL (& if needed, additional comments, ie-vacuum-assist) _____
☐ CESAREAN Reason: _____

Gestational age at delivery ☐ Early (< 37 weeks: what gestational age?_____) ☐ Term (37-42 weeks) ☐ Late (> 42 weeks)

Birth Weight _____ Length _____ Head Circumference _____

Discharge weight _____ Apgar Score _____

Was infant discharged at same time as mother? ☐ Yes ☐ No If not, when? _____

Initial feeding ☐ Breast (How long? _____(wks/mos) ☐ Formula (Type: _____)

Was Hepatitis B vaccine given? ☐ Yes ☐ No If yes, what date was vaccine given? _____ ☐ Date not known

Passed hearing screen? ☐ Yes ☐ No ☐ Not done ☐ Unsure

Did infant have problems at/right after birth? ☐ Yes ☐ No *If yes, please see the following:*

Did your infant have an ICU stay? ☐ Yes ☐ No

Problems included ☐ breathing ☐ temperature ☐ feeding ☐ blood sugar ☐ jaundice ☐ other_____

GENERAL PATIENT HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any medications your child is taking (include dosage/frequency, any other pertinent information (ie-how long your child has been on medication/reason for taking medication)

_____

_____

Does your child have any serious medical conditions? ☐ Yes ☐ No

Has your child had previous hospitalizations? ☐ Yes ☐ No

Has your child had previous surgeries? ☐ Yes ☐ No

Does your child see any specialists? ☐ Yes ☐ No

Has your child had any ER visits in the past year? ☐ Yes ☐ No

Has your child had adverse reactions to immunizations? ☐ Yes ☐ No

Please explain yes answers from above:

_____

_____

_____

_____

_____

☐ Unknown past medical history If adopted, at what age? _____

HOUSEHOLD

Please list who lives in the child's home _____

Please list siblings who do not live at home _____

If one or both parents do not live in the home, how often does the child see the parent(s) not in the home?

_____

Are there pets at home? ☐ Yes ☐ No If yes, how many and what kind are they? _____

Does your child attend daycare or school? ☐ Yes ☐ No Does your child have exposure to any smokers? ☐ Yes ☐ No

Parental status ☐ married ☐ separated ☐ together but not married
☐ divorced/joint custody ☐ divorced/single custody ☐ other (please explain) _____

Parent Occupation: Mother _____ Father: _____

BIOLOGICAL FAMILY HISTORY Mother's Height _____ Father's Height _____

Condition	Patient	Mother	Father	Sibling	MGF*	MGM*	PGF*	PGM*
Freq ear infections								
Problems with ears/hearing								
Nasal/seasonal allergies								
Asthma								
Lung problems (not asthma)								
Pneumonia (recurrent)								
Heart disease/heart problem/history of murmur								
High BP								
High cholesterol								
Prolonged QT								
Anemia								
Bleeding or clotting disorder								
Blood transfusion								
HIV								
Organ or bone marrow transplant								
Cancer								
Liver disease								
Constipation (chronic)								
Celiac disease								
Birth defects								
Cystic fibrosis								
Metabolic/genetic disorder								
Kidney disease								
Bedwetting after age 8 years old								
Sleep problems or snoring problems								
Chronic/recurrent skin problems (ie eczema)								
Frequent headaches/migraines								
Convulsions / seizures								
Infections (frequent/requiring hospital)								
Tuberculosis								
Obesity								
Rheumatologic disorder								
Diabetes (adult-onset)								
Diabetes (juvenile-onset)								
Thyroid disorder								
ADHD								
Anxiety								
Mood disorder (depression/bipolar)								
Developmental delay/learning problems								
Dental decay or teeth problems								
Sickle cell trait/disease								
Bone/muscle disease								
Alcoholism / drug abuse								
OTHER								

* MGF=Maternal Grand Father MGM=Maternal Grand Mother PGF=Paternal Grand Father PGM=Paternal Grand Mother

Has your child had any of the following?

History of fracture(s)? ☐ Yes ☐ No
History of concussion(s)? ☐ Yes ☐ No
History of serious injury? ☐ Yes ☐ No
History of family violence? ☐ Yes ☐ No
Sexually transmitted infections? ☐ Yes ☐ No
Chicken pox? ☐ Yes ☐ No
UTI ☐ Yes ☐ No

IF FEMALE: What was age of first period?_____ Any history of pregnancy? ☐ Yes ☐ No

Your name _____ Signature _____
Relationship to child _____ Today's date _____

Sprout Pediatrics

Delegation of Consent

_____ _____
Name of Patient Date of Birth

I, _____, hearby authorize the following individuals
(parents name)

_____ _____
(Name) (Relationship to child)

_____ _____
(Name) (Relationship to child)

_____ _____
(Name) (Relationship to child)

_____ _____
(Name) (Relationship to child)

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

In case of emergency, I can be reached at: _____
(Contact Number)

_____ _____
Parent Signature Date

Policy Acknowledgement

PRIVACY PRACTICE & OFFICE PROTOCOL ACKNOWLEDGEMENT

1. I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF SPROUT PEDIATRIC'S NOTICE OF PRIVACY PRACTICES.
2. I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF SPROUT PEDIATRIC'S OFFICE POLICIES AND UNDERSTAND MY RESPONSIBILITIES.

Signature: _____

Date: _____

Name of Patient or Patients:

_____

_____

_____

Office Representative Initials: _____

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file with your insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans. **It is your responsibility at EVERY VISIT to**:
   - **Bring your insurance card and photo I.D.**
   - **Pay your Co-Payment and/or any deductibles**. Payment can be made by cash, check or credit card.
   - We accept VISA, MasterCard, American Express and Discover.
   - **Pay in full for any medical care or services that are/were not covered by your insurance plan**.
2. If your child has an insurance that we do not participate with, or your child does not have any insurance, payment in full is expected at the time of service. Your child will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients, if the charges are paid at the time of service.
3. If your insurance plan is an HMO or POS policy it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see your child, but you will be "Private Pay" until the PCP has been changed to one of our physicians.
4. If you do not have your insurance card with you at the time of service, you will be "Private Pay" for that visit. Once you provide us with the insurance card we will submit charges and refund your payment.
5. Proof of insurance is not a guarantee of coverage or of payment.
6. Secondary Insurance: **We do not file secondary insurance**. You may request a copy of the claim to file yourself.
7. **We do not accept Medicaid**.
8. **You are financially responsible for any amount not covered by your child's health insurance plan.**
9. **You are financially responsible for all charges incurred in your child's care and treatment**.
10. If you have questions about your insurance, we can help where possible. However, specific coverage issues should be directed to your insurance company members services department. The telephone number is usually located on your insurance card. In the event that payment is erroneously denied by the insurance carrier, it is your responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier.
11. **If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency**. Accounts are considered past due after 90 days. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
12. To protect your child's records, we ask you to provide our office with a driver's license or other picture ID. Annually, or as changes occur, we will ask you to sign our financial policy and update your registration information. We will scan your insurance card and ID into your child's electronic medical chart. We will check these documents prior to releasing your child's records.
13. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit.
14. Payments will be requested by and returned to **Lala Associates, PA** as Sprout Pediatrics does business under this association.

Late Arrival/No Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule to another day or may be worked back in to the schedule/moved to the end of the day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" three times we reserve the right to discharge your child from the practice. **Appointments that are missed or not cancelled prior to the scheduled appointment time (minimum 1hr prior for same day sick appts and minimum 24hr prior for well check appts) will be charged a No Show fee of $50.00. Future appointments can NOT be scheduled until this fee is paid.**

ADVANCED BENEFICARY NOTICE

These services may NOT be covered by your insurance carrier. The purpose of this list is to help you make an informed choice about whether or not you choose for your child to receive certain services. The fact that your insurance carrier does not cover a service does not mean that you should not receive that service, it just means that you have a choice as to whether your child receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance carrier, you will be financially responsible for the balance on your account.

SERVICE	**CPT Code**
Pure Tone Screening Auditory Test (hearing test)	92551
Screening of visual test acuity (vision test)	99173
Developmental Testing	96110
Preventive Medicine Risk Management (counseling for delayed vaccine schedule)	99401/99402

Additional Fees – See Office Policies for additional details

- After hours call triaged to nurse line - $15 per call
- Forms not completed at time of visit - $10 if simple/signature only, $25 if more complex (ie Asthma action, allergy action, extensive camp packets, college forms etc). Additional $25 rush fee if needed in less than 72 hours
- Collections Fee – 30% of the amount due if your account is sent to collections
- Medical Records not released to another physician - $25 and up per chart for printed copies, $10 for electronic copies

We will not provide medical care to children whose Parents/Guarantors refuse to sign and comply with our financial policy.
Signature of Understanding: I have read and understand the above stated financial policy.

_____	_____	_____	_____
Child's Name	Date of Birth	Child's Name	Date of Birth
_____	_____	_____	_____
Child's Name	Date of Birth	Child's Name	Date of Birth

_____
Patient or Parent/Guardian if Patient is under 18 years of age Date

ASSIGNMENT OF BENEFITS

I, the undersigned authorize payment of medical benefits to Sprout Pediatrics for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child. This information will be used for the purpose of evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

_____
Patient (if 18 or older) Parent/Guardian (if Patient is under 18 years of age) Da**te**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO SPROUT PEDIATRICS

PATIENT'S NAME_____ DATE OF BIRTH_____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient, which is called "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the following purposes:
___Changing Physicians ___Insurance Application ___Billing ___Other: _____

Specific Information to be Used or Disclosed: Date of service(s) : ____All ____ Specified Dates: _____
___ All Medical Records *** Please include Vaccine Records and Growth Charts ***
___Vaccine Records ___ Growth Charts ___ Lab Reports ___ Radiology Reports ___ Specialist(s) Notes
___ Other _____

Persons or Class of Persons Authorized to Make the Use of Disclosure: Sprout Pediatrics

Above information released **FROM**

(Doctor, Hospital, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State, Zip Code) Fax Number

- **I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.**
- **I understand that I may revoke this authorization at any time by notifying Sprout Pediatrics in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by Sprout Pediatrics before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.**

Print Name of Patients Representative

_____ _____ _____
Signature of Parent or Guardian Relationship to Patient Date

Office Representative Initials _____ Faxed Date: _____

SPROUT PEDIATRICS
Afshan Dehlavi, MD, FAAP * Lisa White, DO, FAAP
18338 Kingsland Blvd Suite 210 * Houston, Texas 77094 * Phone 281-599-7334 * Fax 281-599-7040

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

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

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. C-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.

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD DE TEXAS
REGISTRO DE INMUNIZACIÓN (ImmTrac)
FORMULARIO DE CONSENTIMIENTO PARA MENORES

ImmTrac
Texas Immunization Registry

For Clinic/Office Use

(Favor de escribir claramente con letra de molde)

Apellido del Niño(a)

Nombre del Niño(a)

Segundo Nombre del Niño(a)

Fecha de Nacimiento del Niño(a) / / ***Solamente niños menores de 18 años.**

Género: ☐ **Masculino** ☐ **Femenino**

Dirección del Niño(a), Calle

Apartamento #

Teléfono

Ciudad

Estado

Código Postal

Municipio

Nombre de la Madre

Apellido de Soltera de la Madre

ImmTrac, el registro de inmunización de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud de Texas (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizo que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac"). Una vez que la información del menor esté en ImmTrac, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro médico o proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

Al firmar abajo, YO AUTORIZO el consentimiento para registrarlo. Deseo INCLUIR la información de mi niño(a) en el registro de inmunización de Texas.

Alguno de los padres, tutor legal o administrador de bienes: _____
Escriba con letra de molde

_____ _____
Fecha **Firma**

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code,* sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac del DSHS o a un proveedor de salud inscrito.

¿Tiene preguntas? (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

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