REGISTRATION SHEET • HOJA DEL REGISTRO

PLEASE PRINT/ FAVOR DE IMPRIMIR **Today's Date/** Fecha:_____

PATIENT INFORMATION (MINOR CHILD)

Child's Name / Nombre del niño(a)_____

☐ **Male/ N**iño ☐ **Female/ N**iña **Last** / Apellido **First** / Primer Nombre **MI** / Inicial

Date of Birth/ Fecha de Nacimiento_____/_____/_____ **SS#/** Número de Seguridad Social_____

Address/ Dirección_____ **City/** Ciudad_____ **State/** Estado_____ **Zip/** Código_____

Siblings/ Hermanos(as)

Name/ Nombre_____ **Date of Birth/** Fecha de Nacimiento_____/_____/_____

Name/ Nombre_____ **Date of Birth/** Fecha de Nacimiento_____/_____/_____

Name/ Nombre_____ **Date of Birth/** Fecha de Nacimiento_____/_____/_____

Name/ Nombre_____ **Date of Birth/** Fecha de Nacimiento_____/_____/_____

Name/ Nombre_____ **Date of Birth/** Fecha de Nacimiento_____/_____/_____

PARENT INFORMATION (PERSON RESPONSIBLE FOR BILLS)

Name/ Nombre_____ **Relationship to Patient/** Relación al paciente _____

Date of Birth/ Fecha de Nacimiento_____/_____/_____ **SS#/** Número de Seguridad Social_____

Address/ Dirección_____ **City/** Ciudad_____ **State/** Estado_____ **Zip/** Código_____

Home Phone/ Teléfono Casero_____ **Cell/** Célular_____ **Work/** Trabajo_____

Employer Name/ Nombre de Trabajo_____

Employer Address/ Dirección de Trabajo_____ **City/** Ciudad_____ **State/** Estado_____ **Zip/** Código_____

PRIMARY INSURANCE INFORMATION

Insured Party Employer (Employee)/ Empleado_____

Last / Apellido **First** / Primer Nombre **MI** / Inicial

Date of Birth/ Fecha de Nacimiento_____/_____/_____ **Relationship to Patient/** Relación al paciente_____

Address/ Dirección_____ **City/** Ciudad_____ **State/** Estado_____ **Zip/** Código_____

SS#/ Número de Seguridad Social_____ **DL#/** # de Licencia_____ **State/** Estado_____

Employer Ins. Plan?/ ¿Régimen de seguros de trabajo? ☐**YES/**Si ☐**NO**

Insured Party's Employer/ Empleador_____ **Plan Name/** Nombre del plan_____

Policy / ID#/ Política_____ **Group #/** # de Grupo_____

Home Phone/ Teléfono Casero_____ **Cell/** Célular_____ **Work/** Trabajo_____

ADDITIONAL INSURANCE INFORMATION

Insured Party Employer (Employee)/ Empleado_____

Last / Apellido **First** / Primer Nombre **MI** / Inicial

Date of Birth/ Fecha de Nacimiento_____/_____/_____ **Relationship to Patient/** Relación al paciente_____

Address/ Dirección_____ **City/** Ciudad_____ **State/** Estado_____ **Zip/** Código_____

SS#/ Número de Seguridad Social_____ **DL#/** # de Licencia_____ **State/** Estado_____

Employer Ins. Plan?/ ¿Régimen de seguros de trabajo? ☐**YES/**Si ☐**NO**

Insured Party's Employer/ Empleador_____ **Plan Name/** Nombre del plan_____

Policy / ID#/ Política_____ **Group #/** # de Grupo_____

Home Phone/ Teléfono Casero_____ **Cell/** Célular_____ **Work/** Trabajo_____

PARENTAL CONSENT INFORMATION

I,_____**give permission for**

Yo, **Parent/ Legal Guardian/** Padre doy permiso para que

_____,_____**to seek medical treatment for my child in my absence.**

Executor/ Ejecutor **Relationship to Child/** Relación al niño reciba tratamiento medico para mi hijo(a) sin mi precencia.

Witness/ Testigo _____ **Date/** Fecha_____

Emergency Contact Name_____ **Relationship**_____ **Phone Number**_____

Nombre de contacto de la emergencia Relación Número de teléfono

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the Physician of the surgical and/ or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay for non-covered services. I also authorize the Physician to release any information acquired in the course of treatment necessary to process insurance claims.

_____ _____

Signature (Patient or Parent if Minor)/ Firma **Date/** Fecha

Today's Date/ Fecha____/____/_____

PATIENT MEDICAL HISTORY • HISTORIAL MÉDICO PACIENTE

Child's Name_____ **Birth Date**____/____/_____ **Age**_____
Nombre del niño/niña Fecha de nacimiento Edad

FAMILY / FAMILIA

Mother's Age____ **Occupation**_____
Edad de la madre Ocupación

Father's Age_____ **Occupation**_____
Edad del padre Ocupación

Siblings/Hermanos	**Age**/Edad	**Sex**/Sexo	**Health**/Salud

ANY FAMILY HISTORY OF:
ALGUIEN EN SU FAMILIA TIENE UN HISTORIAL DE:

What / *¿Qué?*	***Who? /*** ¿Quién?
Alcoholism/Alcoholismo	
Allergies/Alergias	
Anemia	
Asthma/Asma	
Birth Defects/Defectos de Nacimiento	
Cancer/Cáncer	
Cystic Fibrosis/Fibrosis Cística	
Diabetes	
Drug Abuse/Abuso de Drogas	
Emotional Problems/ Problemas Emocionales	
Epilepsy/Seizures/Fits Epilepsia/Ataques	
Excessive Bleeding or Bruising/ Sangrado o Moretones Excesivos	
Family Violence and/or Child Abuse Violencia Familiar o Abuso Infantil	
Heart Disease/Enfermedad del Corazón	
Heart Attack or Stroke under age 55 yrs Ataque al Corazón o Emolia antes de los 55 años	
High Blood Pressure/Alta Presión	
High Cholesterol and/or Triglycerides Colesterol Alto y/o Triglicéridos	
Sickle Cell Disease/ Anemia de Glóbulus Faláformes	
Other/Otro	

Crept/Crawled/ Arrastró/Gateó _____**months/** meses
Walked alone/ Camió solo _____ **months/** meses

Does anyone in the home smoke? ☐ Yes/Si ☐ No
¿Alguien en la familia fuma?

Is this child often around a smoker? ☐ Yes/Si ☐ No
¿Este niño esta frecuentemente cerca de un fumador?

Does your water have fluoride? ☐ Yes/Si ☐ No
¿Su agua tiena fluoruro? ☐ Unknown/No Sabe

BIRTH HISTORY / ANTECEDENTES DEL NACIMIENTO

Pregnancy #_____**of**_____**total**
(Child #_____ **of** ☐**twins or** ☐**triplets or**_____**)**

Es el embarazo #_____de_____en total
(Es el niño #_____de ☐cuates o ☐trillizos o_____)

Mother's problems/illnesses during pregnancy:
Enfermedades/problemas de la madre durante el embarazo:

_____

☐ **Full Term/** Tiempo Completo
☐ **Premature/** Prematuro_____**weeks/** semanas
☐ **Normal Delivery** ☐ **C-section** ☐ **Breech**
Parto Normal Cesárea Nalgas

Hospital_____
Birth Weight/ Peso al Nacer_____lbs_____ozs
Length/ Longitud_____inches
Apgar Scores/ Puntaje de Apgar_____/_____
Blood Type/ Tipo de Sangre_____
In Hospital/ En el Hospital_____**days/** días
Circumcised?/ ¿Circuncidado? ☐ Yes/Si ☐ No
Complications?/ ¿Complicaciones? ☐ Yes/Si ☐ No

_____

FEEDING HISTORY / ANTECEDENTES ALIMENTICIOS

☐ **Breast Fed** **Every**_____**hours for**_____**minutes**
Se Amamantó Cada_____horas por_____minutos

☐ **Formula** **Name**_____
_____ Nombre de la Leche en Polvo
_____**ounces every/** onzas cada_____ **hours/** horas
Frequent formula changes? ☐ Yes/Si ☐ No
¿Hubo cambios frecuentes en la leche?

Whole milk given at_____ **months** _____**ozs per day**
Se le dio leche entera a los_____meses _____ ozs por día

Milk used: ☐ **whole** ☐ **2%** ☐ **1%** ☐ **½%** ☐ **skim/**
Leche usada: entera descremada

Foods added at_____**months**
Se agregaron alimentos a los_____ meses

Appetite: ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **Picky**
Apetito: Bueno Regular Pobre Quisquilloso

Likes: **meats/** carnes ☐ **vegetables/** verduras
Gustos: ☐ **fruits/** frutas ☐ **cereals/** cereales

☐☐

Rejects: **meats/** carnes **vegetables/** verduras
Rechazos: ☐ **fruits/** frutas ☐ **cereals/** cereales

DEVELOPMENT / DESARROLLO

Rolled over/ Se volteó solo _____ **months/** meses
Sat alone/ Se sentó solo _____ **months/** meses

Clear words/ Palabras claras _____**months/** meses
Sentences/ Oraciones _____**months/** meses
Dry at night/ Seco de noche _____**months/** meses
Grade in school/ Año escolar_____

School performance: ☐ **Good** ☐ **Fair** ☐ **Poor**
Desempeño escolar: Bueno Regular Pobre

Child's Name / Nombre del niño(a)_____ **Today's Date/** Fecha____/____/_____

CHILDHOOD ILLNESSES (CHICKENPOX, EAR INFECTIONS, ETC.)
ENFERMEDADES DE LA NIÑEZ (VARICELA, INFECCIONES DE LOS OÍDOS, ETC.)

Month / Year Mes / Año	**Age** Edad	**What?** ¿Qué?

HOSPITALIZATIONS & SURGERIES
HOSPITALIZACIONES Y CIRUGIAS

Hospital Hospital	**Month / Year** Mes / Año	**Age** Edad	**Reason** Razón

ACCIDENTS & INJURIES (BROKEN BONES, STITCHES, ETC.)
ACCIDENTES Y LESIONES (HUESOS QUEBRADOS, PUNTADAS, ETC.)

Month / Year Mes / Año	**Age** Edad	**What Happened?** ¿Qué Paso?

MEDICINE OR DRUG ALLERGIES
ALERGIAS A MEDICAMENTOS

Drug Medicamento	**Age** Edad	**What Happened?** ¿Qué Paso?

OTHER ALLERGIES (ANIMALS, PLANTS, HAY FEVER, ETC.)
OTRAS ALERGIAS (ANIMALES, PLANTAS, FIEBRE DEL HENO, ETC.)

Allergic to: Alérgico a:	**Age** Edad	**Skin Tested:** ¿Se hizo prueba en la piel?	**What happened?** ¿Qué Paso?
		☐ Yes/Si ☐ No	
		☐ Yes/Si ☐ No	
		☐ Yes/Si ☐ No	
		☐ Yes/Si ☐ No	

DOES THIS CHILD TAKE ANY MEDICINES FREQUENTLY?
¿ESTE NIÑO/NIÑA TOMA MEDICAMENTOS FRECUENTEMENTE?

Medicine Medicina	**Started** Empezó	**How Often?** ¿ Qué Tan Seguido?	**Why?** ¿Por Qué?

AUTHORIZATION FOR RELEASE OF INFORMATION

AUTORIZACIÓN PARA EL LANZAMIENTO DE LA INFORMACIÓN

I hereby authorize:/ Autorizo:

_____

(**Previous Providers or Clinics, Health Dept.** / Doctores Anteriores o Clinicas, Departamento de Salud)

Address (include City/State)/ Dirección_____

Phone/ Teléfono_____ **Fax** _____

to release information to:/ que le de información a:

LONGVIEW PEDIATRICS, PLLC
1009 N Fourth St Suite B
Longview, TX 75601
(903)212-4330 · Fax (903) 212-4333

_____ _____

Patient Name (Please Print)/ Nombre del paciente **Social Security #/** Número de Seguridad Social

_____ _____

Date/ Fecha **Date of Birth/** Fecha de Nacimiento

Information to be released:/ Información que se puede recibir:

____**Initial Examination/** Examinación inicial
____**Follow-up Care Progress Notes/** Notas de progreso
____**Special Procedure Results/** Notas de Procedimientos
____ **Discharge Summary/** Resumen de la Descarga
____ **Office Visit Notes/** Notas de la Oficina
____ **ALL RECORDS/** TODO EL EXPEDIENTE

The above information is released for the following purpose and that purpose only. Any other use is forbidden: ESTABLISH CARE WITH LONGVIEW PEDIATRICS.
La información antedicha se lanza para el propósito siguiente y ese propósito solamente. Se prohíbe cualquier otro uso: ESTABLEZCA EL CUIDADO CON LONGVIEW PEDIATRICS.

ALL RECORDS include any and all medical records regarding my treatment, hospitalization and/or outpatient care for my condition including, but not limited to, psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), AID's related complex (ARC), and HIV antibody testing.

This authorization will expire thirty (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:
Esta autorización expirará treinta (30) días a partir de la fecha de mi firma o según lo especificado de otra manera por la fecha, acontecimiento, o condicione como sigue:

_____ _____

Signature of Parent or Authorized Legal Representative/ Firma **Date/** Fecha

_____ _____

Relationship to Patient/ Relación al paciente **Witness Signature/** Testigo

Longview Pediatrics, PLLC
FINANCIAL POLICY

Thank you for choosing Longview Pediatrics as your health care provider. A patient information sheet and current insurance information is required before seeing the provider. It is your responsibility to inform our office of any changes involving these documents.

The following are our requirements for payment of medical services:

Regarding Fee for Service Patients
We require payment in full for services provided to patients with no insurance. Payment may be made by cash, check, money order, or credit card. There will be a $35.00 fee on any returned checks.

Regarding Financial Arrangements
We understand that sometimes medical costs can be high and/or the funds are not readily available and payment arrangements are necessary. It is our policy that these arrangements be made prior to services being performed.

Regarding Insurance
We will accept assignment of benefits from your primary insurance and one other insurance. A copy of your insurance card(s) is required by our office, and any changes must be brought to our office. If your policy has a deductible or patient responsibility co-pay, then you will be required to make that payment at the time of service unless prior arrangements have been made. **Failure to provide our office with current insurance information that leads to non-payment from the insurance company will result in the balance being transferred to patient responsibility.**

Regarding Non-Covered Services
Please be aware that Medicaid and some insurance companies consider certain services as non-covered services, therefore, you will be expected to pay for these services.

Regarding Insurance Plans Where We Are A Participating Provider
All co-pays and deductibles are due prior to treatment.

Regarding Past Due Patient-Responsibility Account Balances
If no payment has been made on the patient-responsibility balance within 90 days, we will charge interest on that balance at a rate of 7%, compounded annually, beginning with the 91st day.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area.

I have read and agree to abide by the terms of this financial policy.

_____ _____

Signature of Parent/Responsible Party Date

Longview Pediatrics, PLLC
1009 N Fourth St, SuiteB
Longview, TX 75601

AUTHORIZATION FOR TREATMENT

Medical care is a patient care service provided in response to a wide range of medical care needs of all ages regardless of gender, color, race, creed, national origin, or disability at Longview Pediatrics.

The purpose of medical care is:

- To treat disease, injury, and disability by examination, testing, and use of procedures in the aid of diagnosis and treatment.
- To obtain information needed in diagnosing and examining patients.
- To prevent or minimize residual physical and mental disability.
- To aid patients in achieving their maximum potential within their capabilities.
- To accelerate convalescence and reduce the length of functional recovery.

All the procedures will be thoroughly explained to you before they are performed. You are not expected to experience any increase in your current level of pain or discomfort. You should stop any procedure before you experience any increase in your current level of pain or discomfort.

This facility has on staff a Nurse Practitioner. He/she has received advanced training and education in the provision of health care. He/she can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

Based on this information, I agree to cooperate fully, to participate in all medical care procedures, and to comply with the plan of care as it is established. I hereby consent to the services of a physician or mid-level (physician assistant /nurse practitioner).

For your personal safety, do not use any equipment or enter the laboratory area without permission.

I acknowledge that I have read and received copies of the Authorization for Treatment and Patient's Rights and Responsibilities.

_____ _____

Patient Name Date

_____ _____

Patient/Parent Signature Witness

Longview Pediatrics, PLLC

1009 N Fourth St, Suite B

Longview, TX 75601

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

RECONOCIMIENTO DE LAS PRÁCTICAS DE LA AISLAMIENTO

I,_____acknowledge that

Yo (**Name of Guardian/** Nombre del Guarda) reconozca que he

I have read and understand the Notice of Privacy Practices as given

leído y entiendo el aviso de las prácticas de la aislamiento dado

to me this_____day of_____, 20___.

a mí este (**Day/** Día) día de (**Month/** Mes) (Year/ Año)

Signature/ Firma_____

Printed Name/ Nombre_____

Witness/ Testigo_____

Patient Name/ Nombre del Paciente_____

Social Security Number/ Número de Seguridad Social

Longview Pediatrics, PLLC

Dear Valued Parent,

We would like to inform you of our policy concerning well child appointments. Due to recurring delays, extra paper work, and time constraints, we ask that you check in fifteen (15) minutes (per child) prior to your scheduled appointment time. If you are unable to arrive on time, we will assist you in rescheduling your appointment. Your cooperation with this policy will allow us to give your family quality care in a timely manner. Thank you for your assistance.

Please bring your child's shot record with you to each visit and we will keep it up- to-date. If you lose the shot record and require a replacement, there will be a nominal charge at the time of replacement. Thank you for your consideration.

In order to be able to provide same day sick visit appointments and schedule well child appointments in a timely manner, we also have a no show policy. We ask that you please call at least 24 hours in advance if you are unable to keep your child's appointment. Failure to do so will report in a no call/no show status for that appointment. After 3 no call/no shows, Longview Pediatrics may dismiss you and your children from the office.

Sincerely,

Amanda Prince, RN, CPNP

_____

Signature of Parent or Legal Guardian

_____

Date