



ELDRIDGE POINTE PEDIATRICS

126 Eldridge Rd., Unit D.
Sugar Land, TX 77478
Phone: (832) 939-8956; Fax: (832) 930-4748

PATIENT REGISTRATION

Today's Date: _____

Completed By: _____ Relationship to patient: _____

PATIENT'S INFORMATION

Name: _____ Nickname: _____ DOB: _____
Last First MI

Sex: Female Male Race: Caucasian African American Hispanic Asian
 Other: _____

Address: _____
Street Number City State Zip

Home Phone #: _____ Alternating phone#: _____

School: _____ Grade Level: _____ Preferred Language: _____

Child lives with: _____

Please tell us how you chose us: Drive by Advertisement: (please specify) _____
Referred by: Friend: _____ Relative: _____
 Doctor: _____

PARENTS' INFORMATION

Mother's Name: _____ **DOB:** _____ **SS#:** _____

Address (if different from above): _____
Street City State Zip

Phone #: _____ Cell #: _____ Work #: _____

Receive Text message: Yes No

Occupation: _____ Company: _____

Driver License #: _____ State: _____ Email: _____

Father's Name: _____ **DOB:** _____ **SS#:** _____

Address (if different from above): _____
Street City State Zip

Phone #: _____ Cell #: _____ Work #: _____

Receive Text message: Yes No

Occupation: _____ Company: _____

Driver License #: _____ State: _____ Email: _____

OTHER CAREGIVER INFORMATION (Other than parents)

Name: _____ Relationship to patient: _____

Address (if different from above): _____
Street City State Zip

Phone #: _____ Cell #: _____ Work #: _____

Receive Text message: Yes No

Driver License #: _____ State: _____ Email: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone #: _____

CONSENT FOR TREATMENTS/PAYMENTS

- 1) I authorize Eldridge Pointe Pediatrics and staffs to provide medical services to the patient listed above
- 2) I authorize the payment of insurance benefits for the patient listed above to Eldridge Pointe Pediatrics / Dr. Jamie Ngo. I understand that I am responsible for any balance not paid by my insurance
- 3) I understand that I am responsible to pay for service rendered, including reasonable attorney's fees and costs of collections in the event of default.

Signature: _____ Date: _____



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CONSENT TO TREAT

I, _____, the parent/legal guardian of _____ hereby give my consent for and authorize the administration and performance of all medical care, treatment, and diagnostic procedures which in the judgment of the licensed physicians, nurses, and health care professionals of Eldridge Pointe Pediatrics are believed to be medically necessary. I understand that all such services will be provided according to generally accepted standards of pediatric medical care and in accordance with applicable state law. Included among the medical care services provided will be the administration of immunizations as required by law and generally recommended by the American Academy of Pediatrics and Center for Disease Control (CDC).

I acknowledge that I may revoke or change this Consent in writing addressed to Eldridge Pointe Pediatrics.

Parent/legal guardian signature: _____

Name: _____ Relationship: _____

Effective Date: _____



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PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing Eldridge Pointe Pediatrics for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities includes:

- The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing by mail, phone or auto-payment using your credit card saved on file.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

Charge for returned checks - \$30.00

No Show/No Call fee - \$25.00

By signing the Patient Acknowledgement and Authorization form, I hereby authorize assignment of financial benefits directly to ELDRIDGE POINTE PEDIATRICS for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law.

Patient Name _____ DOB: _____

Patient/Guardian Signature _____

Date: _____

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



(Please print clearly)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Child's Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

For Clinic/Office Use

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Child's First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Child's Middle Name

						/						/						
--	--	--	--	--	--	---	--	--	--	--	--	---	--	--	--	--	--	--

**Children under 18 years only.*

Child's Date of Birth

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 Stock No. C-7
 Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347 Revised 05/18/2012



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.



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Acknowledge of Receipt of a Copy of HIPPA Notice and Office Policy

Patient's Name

DOB

Date

Signature

Print name

Relationship to patient

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____

DATE COMPLETED _____

BIRTH DATE _____

AGE _____

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

- Lives with adoptive parents Joint custody Single custody
 Lives with foster family

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

Birth History Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

During pregnancy, did mother

Use tobacco Yes No Drink alcohol Yes No

Use drugs or medications Yes No Used prenatal vitamins

What _____ When _____

Was the delivery Vaginal Cesarean If cesarean, why? _____

Was initial feeding Formula Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

Yes No Explain _____

General DK = don't know

Do you consider your child to be in good health? Yes No DK Explain _____

Does your child have any serious illnesses or medical conditions? Yes No DK Explain _____

Has your child had any surgery? Yes No DK Explain _____

Has your child ever been hospitalized? Yes No DK Explain _____

Is your child allergic to medicine or drugs? Yes No DK Explain _____

Do you feel your family has enough to eat? Yes No DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

Biological Family History (Continued from front side.) DK = don't know

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sleep problems; snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Has had first period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of first period _____	
Any other significant problem _____				

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.*

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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DR. NGO
 DR. DANG
ACT #:



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**REQUEST FOR RELEASE AND TRANSFER OF MEDICAL RECORDS TO
ELDRIDGE POINTE PEDIATRICS**

The undersigned _____,
Printed Name of Legal Guardian/Parent

➤ Legal Guardian/Parent of _____,
Printed Name of Patient

➤ DOB: _____, hereby authorizes and requests:
Patient's Date of Birth

Name of Patient's Previous Physician or Group

Address of Previous Physician or Group

Phone Number of Previous Physician or Group

To release:

__ Entire medical records

or:

__ Immunization records & Growth charts

__ Problem list

__ Consultation reports

__ Important labs / diagnostic studies

__ Medication list

__ Allergy

Please fax immunizations and growth chart to (832) 930-4748 and mail all other records to:

ELDRIDGE POINTE PEDIATRICS
126 Eldridge Rd, Unit D.
Sugar Land, TX 77478
Phone: (832) 939-8956

Signature of Parent/Legal Guardian

Date