TEXAS PEDIATRIC SPECIATLIES AND
FAMILY SLEEP CENTER
REGISTRATION FORM – PEDIATRIC

(Please Print)

Referring Physician:_____ Primary Care Physician:_____

Patient's **LEGAL** Last name: _____ First:_____Middle Initial: ____

Patient date of birth ____/____/_____ Patient Ethnicity: _____

Primary home street address:_____ Apt #: _____

City: _____ State: _____ Zip: _____ Social Security#: _____-____-_____

Primary parent email address: _____

Home phone ( ) _____ Cell phone ( ) _____Employer phone ( )_____

Ok to leave a voicemail at the numbers listed? Yes/No If so, preferred # ( )_____

In case of an emergency, who should we notify:_____Phone #_____
Relationship to patient:_____

Is this person authorized to make medical decisions? Yes/No If not, please provide a contact that is authorized to make medical decisions:

Name:_____Relationship to patient: _____

INSURANCE INFORMATION

Subscriber's Name:_____ Date of Birth: ____/____/_____

Subscriber's SS #:____-____-_____ Relationship to patient:_____

Insurance Name: _____ Subscriber ID #: _____ Group #: _____

Secondary Insurance: YES / NO

Subscriber's Name: _____ Date of Birth: ____/____/_____

Subscriber's SS#: ____-____-_____ Relationship to patient: _____

Insurance Name: _____ Subscriber ID #: _____ Group #: _____

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Texas Medical & Sleep Specialists or my insurance company to release any information required to process my claims.

_____ _____
Signature of Parent, Guardian or Responsible Party Date

_____ _____
Printed name of parent, guardian or responsible party Relationship to patient

Printed name of patient (or responsible party) **Witness**

Medical History

Patient Name: _____ Date of birth: _____/_____/_____

Has the patient ever stayed overnight in the hospital? (Yes / No)
If yes, when and for what? _____
_____
_____

Has the patient ever been to the Emergency Room? (Yes / No)
If yes, when and for what? _____
_____

Previously diagnosed medical problems: _____
_____
_____

Previous surgeries: _____

ALLERGIES TO MEDICATIONS? (If yes, which medication and what happened?)

_____

Does patient have any food allergies? _____
Does patient have any environmental allergies? (Ex: pollen, oak, dust, cockroaches, pets) _____
_____

Medications (please include strength, dose, and frequency) Ex: Zyrtec (5 mg/ml) 1 teaspoon (5 ml) every night

_____
_____
_____
_____
_____
_____

Birth History

1. How many weeks pregnant was the mother at the time of birth? _____
2. How much did the infant weigh at birth? _____
3. Was child born by c-section or vaginally? _____
4. Was child a singleton, twin, or triplet? _____

NICU History

1. Did child spend any time in the NICU? _____
2. If yes, how long and which hospital? _____
   Why? _____
3. Was child diagnosed with any medical problems while in the NICU? (Yes / No)
   If so what? _____
   _____
4. Any procedures while in the NICU? _____
   If so what? _____
5. Was child on oxygen either thru a ventilator or a nasal cannula? _____
6. How many days on oxygen? _____

Specialty Questions:

1. Are the patient's immunizations up to date? _____
2. Has patient ever received Synagis injections? _____
3. When was the last **YEAR** the patient received the flu vaccine? _____
4. Has patient had allergy testing? (Yes / No) If so, where & when? _____
5. Do any of the patient caregivers work in a dusty environment? (Yes / No) _____

Other information you think we need to know? _____

Family History

Please tell us about the patient's family medical history. Do any medical problems run in the family?

Medical problems such as: (please circle all that apply)

- allergies, asthma, eczema, recurrent sinus infections, recurrent ear infections, cystic fibrosis, chronic bronchitis, emphysema, tuberculosis, or other lung diseases
- acid reflux, autoimmune diseases, HIV/AIDS, hepatitis
- high blood pressure, heart disease, heart attack, stroke, seizures, diabetes, cancer, thyroid gland problems, kidney problems, anemia, or other diseases
- snoring, sleep apnea, sleep walking, sleep talking, restless legs, periodic limb movement disorder, insomnia, SIDS, or other sleep disorders
- Other _____

If you circled any of the above, which family members?

Mother:_____ Mother's side: _____

Father:_____ Father's side: _____

Sibling(s):_____ Aunts/Uncles: _____

Cousins:_____ Others: _____

Social History

Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

Please tell us about the patient's environment and social situation. Please bubble all that apply.

Please tell us about the patient's environment:

O house O apartment O trailer home O central A/C
O window A/C units O dehumidifier O humidifier O change air filters regularly
O hypoallergenic mattress encasement(s) O hypoallergenic pillow encasement(s)
O stuffed animals in the bedroom O carpet in the bedroom
O carpet throughout the home O mildew/mold problems in the home
O upholstered furniture O wood or leather furniture
O drapes/curtains on the windows O blinds on the windows

Does the patient drink alcohol, or is there alcohol consumption in the patient's environment?

O daily O weekly O monthly
O less than once a month O special occasions only O none

Does the patient smoke or is the patient exposed to smoke?

O Less than 1 pack per day O 1 pack per day O 1-2 packs per day
O Greater than 2 packs per day O Second hand smoke exposure
O Smoke exposure inside the home/car
O No smoke exposure

Who lives in the home with the patient?

O Mom O Dad O Both Parents O Foster Parent
O Siblings O Spouse O Children O Other

What type of work does the patient (or patient's parent(s)) do?

O Professional O Medical Field O Laboratory Work O Hard Labor
O Work in the Home O Exposure to Toxins and/or Chemicals O Other

Has the patient traveled or lived outside the United States? O Yes O No

What is the patient's (or patient's parent(s)) marital status?

O Single O Married O Divorced O Other

Is the patient exposed to pet(s) or animals? If so, how many?

O Dog(s) O Cat(s) O Bird(s) O Cattle O Horse(s) O No pet/animal(s)

Does the patient attend school?

O Elementary O Middle O High School O College
O Not in school O Involved in organized sports O Does not play sports
O Involved in extra-curricular activities

Does the patient (or patient's family) have daycare exposure? O Yes O No

Review of Systems

Name: _____ Date of Birth: ___/___/____ Today's Date: ___/___/_____

During the past few weeks, have you had any of the following symptoms? Please bubble all that apply.

CONSTITUTIONAL:
O fever O chills O night sweats
O fatigue O loss of energy O loss of appetite
O unexpected weight loss or gain O no general complaints
O problems with sleeping O snoring
O breathing difficulties O choking/gasping/snorting during sleep
O excessive sleepiness during the day O morning headaches
O dry mouth/sore throat upon wakening O difficulty falling asleep
O frequent awakening during the night O excessive movements during sleep
O other sleep difficulties O no sleeping problems

EYES:
O dry eyes O eye pain
O watery eyes O itchy eyes
O vision changes
O no eye complaints

EARS, NOSE AND MOUTH:
O nasal congestion O sinus pressure O facial pain O ear pain
O nasal discharge O nose bleeds O nasal ulcers O tooth pain
O ear discharge O dry mouth O oral ulcers O enlarged tonsils
O bad breath O postnasal drip O sore throat O no complaints
O recurrent strep throat O sensation of fluid or fullness in the ear

HEART:
O chest pain O palpitations O racing heart rate
O shortness of breath O swelling in the legs O no complaints

LUNGS:
O shortness of breath at rest O shortness of breath with normal daily activities
O shortness of breath with exercise O wheezing
O cough with sputum production O cough without sputum production
O blood tinged phlegm or coughing up blood O no lung complaints

STOMACH AND INTESTINES:
O nausea O vomiting O diarrhea O constipation
O abdominal pain O heartburn O jaundice O abdominal fullness O no complaints

GENITO-URINARY SYSTEM:
O painful urination O blood in urine O urgent or frequent urination O no complaints

PSYCHIATRIC:
O depression O anxiety O panic attacks O no complaints

MUSCLES AND JOINTS:
O joint pain O joint swelling O joint stiffness O muscle aches O muscle weakness
O no complaints

NEUROLOGICAL SYSTEM:
O headache O seizures O tremors
O vision changes O weakness O sensory changes
O difficulty with memory O no neurological problems/complaints

SKIN:
O eczema (dry/itchy skin) O rash O hives
O psoriasis O no skin complaints

HEMATOLOGICAL/LYMPHATIC SYSTEM:
O easy bruising O easy bleeding O history of blood clots (DVT) O blood clot antibody
O no complaints O swollen lymph nodes O no swollen lymph nodes

ENDOCRINE AND METABOLISM:
O heat intolerance O cold intolerance O frequent need to urinate
O always thirsty O intermittent vision changes
O problems with your thyroid O no complaints

ALLERGY/IMMUNOLOGY*:*
O anaphylaxis O angioedema
O frequent infections O no complaints

Electronic Prescriptions

We subscribe to an electronic prescription service. Our physicians transmit e-prescriptions via a secured internet network directly to participating pharmacies. Please list your pharmacy name, address and phone number below. TMSS has the ability to download my pharmacy benefits and medication history through a secure internet network. This will allow your physician to prescribe medications covered by your health insurance plan and also prevent any medication allergies or duplicate prescriptions from being prescribed.

By signing below, I give my permission for TMSS to download this information from the above pharmacy. **This is an OPTIONAL service provided by TMSS. If you do not wish to participate, feel free not to sign below.**

Effective October 1, 2018

All refill requests will be processed through your patient portal. Please allow 24 to 72 hours to process. You can also contact your pharmacy and your pharmacy will contact our office. We will no longer process patient phone call refill requests.

If you do not have a patient portal account, please ask the receptionist for details.

Patient's Name:
_____

Name of Pharmacy:
_____

Pharmacy Address:
_____

Pharmacy Phone #: (_____) _____ - _____

_____ _____
Patient or Guardian Signature Date

Acknowledgement of Receipt of Notice of Privacy Practice

By signing this form, you are granting consent to Texas Pediatric Specialties and Family Sleep Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our health information office at: 210-249-5020.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Name (Print): _____

Signature: _____

Date: _____

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this

Acknowledgement but did not because _____

_____

Signature of Privacy Officer

Tarak Patel, M.D
Kelly J. Smith, M.D
Jerry Tomasovic, M.D
Michael Marsh, M.D

Carter Richards, M.D
Avie Grunspan, M.D
Lesley Vernor, NP
Heather Digiovanni, PA

Pediatric, Pulmonary, Neurology & Sleep Medicine for Adults & Pediatrics

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AUTHORIZATION FOR MEDICAL TREATMENT of a MINOR

CHILD: _____ DOB: _____

I _____ _____ _____
Legal Custody/Guardian | Address (Street, City, Zip Code) | Phone Number

declare I have legal custody and am the guardian of the child mentioned above. I give the following permission:

- To attend appointments with mentioned child at Texas Pediatric Specialties and Family Sleep Center
- To receive medical information for the mentioned child
- To authorize medical treatment or medical procedures for the mentioned child

_____

_____ _____ _____
Full Name (ID must be presented at DOS) | Address (Street, City, Zip Code) | Phone Number

_____ _____ _____
Full Name (ID must be presented at DOS) | Address (Street, City, Zip Code) | Phone Number

Legal Guardian Signature: _____

Legal Guardian Printed Name: _____

Date: _____

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Consent to Leave Messages/Share Information with Family/ Friends

I understand that in order for Texas Pediatric Specialties & Family Sleep Center (TPS &FSC) to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to TPS & FSC.

Consent for Leaving Messages:

I give consent to TPS & FSC to leave a message on my voicemail/answering machine about my child's lab results. I understand that "sensitive information as noted below will be excluded.

☐ Yes ☐ No

Consent for shared information with Family & Friends:

The Name(s) listed below are family members or friends to whom I grant permission for my child's health care provider and their representatives at TPS & FSC to verbally discuss their care using their best judgement and grant them permission to disclose health information that is relevant to their care.

☐ Yes ☐ No

Under the HIPPA Privacy Law we are permitted and we may make a professional judgement that certain disclosures are in your best interest even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my/my child's protected healthcare information will be provided without my signature on a release of Information Form.

I understand that some information, as listed below, is considered "sensitive." I understand that I must check the specific boxes in order for my provider or his/her designee to release any "sensitive" information.

- Medical Conditions
- Mental Health/ Psychiatric disorders(including Depression)
- Chemical Dependency(Drug and/or alcohol abuse/treatment)
- Pregnancy Information

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

Patient's Name (Please Print):_____ **DOB:** _____

Patient or Parent\Guardian Signature: _____ **DOB:** _____

Our Financial and Office Policies

Thank you for choosing Texas Pediatric Specialties and Family Sleep Center as your healthcare provider. We are committed to providing our patients with the best available medical care. Our billing department will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and sign our financial and office policies and complete the patient information form prior to seeing the physician. As you read, please initial beside each topic to indicate your understanding of our policies.

_____1**. Demographic Information**- Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing in the near future).

_____2.**Copay** -All co-pays, deductibles, and/or co-insurances are due at the time of service.

_____ 3. **Balances**- If you have balance on your account we will ask for payment. We accept cash, check, Visa and MasterCard. We allow 90 days for payment of any balances that are the responsibility of the patient. If we do not receive full payment in 90 days, the account will be referred to collections. If your account is sent to collections, you will incur **ALL** fees associated. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing.

_____4**. Insurance Verification**-We verify insurance benefits as a courtesy to our patients. Not all services are a covered benefit in your medical plan. Please contact your insurance company if you have questions regarding your health care coverage. Texas Pediatric Specialties and Family Sleep Center provides services that are medically necessary in the physician's professional opinion. If you are unsure if a procedure, immunization or injection is covered, please call your insurance company prior to receiving services. You are ultimately responsible for all charges that are not covered under your health care policy. Please remember that your insurance is a contract between you (or your employer) and the insurance company. We are not a party to that contract**.**

_____ 5. **Referrals**-If your appointment requires a referral from you primary care physician, that referral will need to be on file with our office before the appointment day. Please contact your primary care physician to ensure this referral is sent to our office in time for the upcoming appointment. If you are seen without a referral on file and the insurance company does not pay, you will be responsible for all charges.

★ _____6. **No Show Fee**-

- If you are more than 20 minutes late for your appointment, it is considered a **(No-Show**). A $50.00fee will be applied.
- Appointments not canceled with a **24 hour notice** will be subject to a charge of $50.00.
- After **3 "no show"** appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and to the referring physician. Should the physician choose not to terminate the relationship, we reserve the right to charge a $50.00 deposit for any future appointments. This deposit can be applied to any copay, co-insurance or deductible due at time of service or the deposit will cover the cost of the no show fee.

_____7. **Returned Checks**-Any personal check that is returned due to insufficient funds will be subject to a $35.00 charge in addition to the amount of the check. After one instance of a returned check, all further payments will be required to be in the form of credit card, cash or money order only.

_____8. **Medical Records**-There is a $25.00 fee for the first 20 pages and $.50 thereafter for copies of medical records not requested by another physician. The patient, parent or guardian must complete an authorization to disclose health information.

____9.**FMLA**- There is a $25.00 fee to complete any FMLA paperwork. Please allow 7-10 business days for completion.

_____10. **Prescription Refills**-ALL prescription refills are transmitted via e- prescriptions via a secured internet network directly to participating pharmacies. You can have your pharmacy submit the refill request electronically or they may fax the request. We DO NOT accept calls directly from patients for refills. Please do not wait until you are out of medication to ask your pharmacy for a refill. **We require 5 business days to respond to a refill request. Please note that we do not process refill requests on the weekends or holidays.** The patient must have a follow-up appointment scheduled or have been seen within the last 6 months in order to have any prescriptions refilled.

_____11. **Triplicate prescriptions** (Triplicate prescriptions are for Schedule II controlled substances): All expired Triplicate prescriptions that are not filled must be returned to our office. Triplicate prescriptions must be filled within 21 days. There is a $5 fee for each triplicate prescription that is picked-up in a timely manner and a $25 fee for expired triplicate prescriptions (i.e. not picked-up in a timely manner). Triplicate prescriptions can be mailed certified for a fee of $25.00 in addition to the regular $5.00 refill fee.

I HAVE READ AND I UNDERSTAND THE ABOVE POLICIES

_____ ____/____/_____

Signature of patient (or responsible party) **Date**

_____ _____

Printed name of patient (or responsible party) **Witness**