STEP PEDIATRICS, P.A
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4800 W. PANTHER CREEK, STE 100, THE WOODLANDS, TX 77381
P: 281-364-8600 F: 281-298-2005

DATE ____________________

PATIENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH SEX PRIMARY CONTACT NUMBER

ADDRESS CITY STATE ZIPCODE

FATHERS NAME CELL PHONE WORK NUMBER EMAIL ADDRESS

MOTHERS NAME CELL PHONE WORK NUMBER EMAIL ADDRESS

EMERGENCY CONTACT PHONE NUMBER RELATIONSHIP TO PATIENT

BILLING PARTY INFORMATION/INSURANCE INFORMATION

INSURED NAME (CARD HOLDER) ADDRESS

TX DRIVER'S LICENSE NUMBER SOCIAL SECURITY NUMBER DATE OF BIRTH

CELL PHONE WORK PHONE EMAIL ADDRESS

EMPLOYER ADDRESS

PRIMARY INSURANCE ADDRESS (LOCATED ON THE BACK OF YOUR INSURANCE CARD)

POLICY NUMBER GROUP NUMBER INSURANCE PHONE NUMBER

ADDITIONAL INFORMATION

PRIMARY LANGUAGE SPOKEN AT HOME SECONDARY LANGUAGE AT HOME

PREVIOUS DOCTOR FOR PATIENT HOW DID YOU HEAR ABOUT US?

PREFERRED PHARMACY: NAME, PHONE NUMBER AND LOCATION

AMERICAN INDIAN/NATIVE AMERICAN ASIAN BLACK/AFRICAN AMERICAN HISPANIC/LATINO WHITE/CAUSASIAN PACIFIC ISLANDER OTHER:

WHAT IS YOUR ETHNICITY? (PLEASE CIRCLE ALL THAT APPLY)

PEDIATRIC NEW PATIENT QUESTIONNAIRE
4 OR YOUNGER

Name: ______________________________________

Date of Birth: ______________________________________

Today's Date: ______________________________________

Dear Parents: Please complete as much of this form as you can.

It will help us learn more about your child and help us to give them a better examination.

Current Information

What is the reason for today's visit? ______________________________________

____

Is your child now taking any medications? ______________________________________

List any medications to which your child may be allergic and describe the reaction: ______________________________________

____

____

Does your child have any sever reaction to foods or insect bites? ______________________________________

____

Past History

Pregnancy and birth (this child)

Age of mother at time of birth: ______________________________________

Total number of pregnancies: ____________ Living children: ____________ Miscarriages or stillbirths: ____________

This was pregnancy number: ____________

This pregnancy was: □ 9 months □ premature □ prolonged

Was the pregnancy complicated by: □ anemia □ bleeding □ high blood pressure □ illness or infection □ diabetes □ need for any medication

□ Other ______________________________________

____

Where was this child born? ______________________________________

Birth Weight: ____________________ Length: ____________________

Was the delivery: □ breech delivery □ Caesarean section □ forceps delivery □ under general anesthesia (gas) □ difficult/prolonged

□ Other ______________________________________

Feeding History

Breastfed ____________ months. Formula fed ____________ months. Name of formula: ____________

Solid food began at ____________ months. Table food at ____________ months. Does your child eat well? ____________

Are there foods your child cannot eat (list)? ______________________________________

Do you give vitamins? ____________________ Name(s): ____________________

Growth and Development

Cities in which child has lived: ______________________________________

Do parents or caretakers smoke? □ Yes □ No

Are there pets in the home/yard? ______________________________________

Does patient eat dirt, paint of other non-food items? ______________________________________

Please list any hospitalizations, operations, injuries, or serious illnesses and the year or age they occurred:

____

____

____

Immunizations

Is our child up to date? ______________________ (Please provide us with a copy of the immunizations.)

Hospitalizations and medical problems

Please list any hospitalizations, operations, injuries or serious illnesses and the year they occurred: ____________________

____

____

____

OVER

PEDIATRIC NEW PATIENT QUESTIONNAIRE
4 OR YOUNGER

Family History

	Name	Age/Height/Weight	Condition of Health	Occupation
Mother	___________________	____________________	_____________________	___________________
Father	___________________	____________________	_____________________	___________________
Siblings	___________________	____________________	_____________________	___________________
	___________________	____________________	_____________________	___________________
	___________________	____________________	_____________________	___________________
	___________________	____________________	_____________________	___________________

Please list relationships of immediate or extended family members who have the following problems:

Allergies: ____

Asthma: ____

Blood disorders, including Sickle Cell: ____

Birth Defects: ____

Bleeding problems: ____

Convulsions or epilepsy: ____

Cystic Fibrosis: ____

Diabetes (adult or childhood): ____

Heart disease in children: ____

Hears disease in adults under 55 years:

Heart attacks: ______________________ Hardening of the arteries: ______________________

Strokes: ______________________ Heart bypass: ______________________

Angina: ______________________

High cholesterol (over 240 or on medication): ____

High blood pressure: ____

Intellectual disability: ____

Migraine headaches: ____

Thyroid disease: ____

Other: ____

Does your child have a history of the following problems? (Now or in the past)

□ Allergy, hay fever, or sinus problems
□ Asthma, wheezing, or shortness of breath
□ Bronchitis or pneumonia
□ Chronic cough
□ Frequent ear infections
(How many? ______ Needed PE tubes? _____)
□ Frequent throat infections, tonsillitis, or colds
□ Hearing Problems
□ Heart murmur or other heart problems
□ Convulsion, febrile seizure, or staring spells
□ Head injury or concussion
□ Unusual clumsiness
□ Eating problems
□ Excessive sweating
□ Excessive thirst
□ Growth problems or weight loss
□ Abdominal pain, chronic
□ Bloody or tarry stools
□ Constipation or diarrhea
□ Vomiting or nausea, chronic
□ Anemia
□ Easy bleeding or bruising
□ Sickle cell trait or disease
□ Chickenpox
□ Measles
□ Exposure to tuberculosis
□ Frequent unexplained fever
□ Deformity or swelling of limbs
□ Urinary tract or bladder infections
□ Frequent or painful urination
□ Eczema or other skin problems

Step Pediatrics, P.A
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4800 West Panther Creek, Ste.100 The Woodlands, TX 77381
281-364-8600 Phone 281-298-2005 Fax

Newborn Insurance Waiver

Name of Patient: ___________________________________

Dear Parent:

We understand your baby has not yet been added to any insurance. To give you time and opportunity to do this, we give you a 15-day grace period in which we will treat your child without collecting at time of service.

The grace period is only for a newborn between the age of 1 and 15 days and only while he/she is not covered by any insurance. Once the child has been added to insurance, we will collect according to the benefits.

We encourage you to add the child to your insurance as soon as possible to ensure timely filing of all claims. You can notify us of new enrollment by calling 210-494-2223 and selecting the prompt for Benefits or Billing.

By signing this waiver, you understand that after your child is 16 days or older, the child will be considered a Self-Pay patient and we will collect accordingly at time of service and request payment for any balances incurred.

All monies will be promptly refunded once child is placed under insurance and reimbursement is received from the insurance payer.

_________________________________ _________________
Signature of Parent accepting responsibility Date of service

_________________________________ _________________
Signature of Clinic Representative Date of service

Texas Immunization Registry (ImmTrac2) Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name ______ Child's Middle Name ______ Child's Last Name ______

Child's Date of Birth (mm/dd/yyyy) ___/___/_____ Child's Gender: ☐ Male ☐ Female Telephone ___-___-____ Email address ______

Child's Address ______ Apartment # / Building # ______

City ______ State ______ Zip Code ______ County ______

Mother's First Name ______ Mother's Maiden Name ______

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization Registry, 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, and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

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 ______ Signature ______ Date ______

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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Provider Statement

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com

Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347