STEP PEDIATRICS, P.A
JOAN PURCELL, MD M. RYAN KOZAK, MD AMANDA CHAVEZ, MD VERIAH PLASENCIA, MD
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

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

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

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

TEXAS Health and Human Services | Texas Department of State Health Services

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)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ 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

STEP PEDIATRICS
4800 West Panther Creek Ste 100 The Woodlands TX 77381
Phone: 281-364-8600 **Fax 281-298-2005**

Authorization for : ☐ Disclosure ☐ Inspection ☐ Amendment Of Protected Health Information

PATIENT NAME **DATE OF BIRTH** **SSN**

ADDRESS **TELEPHONE #**
( )

I hereby authorize_____
Print Name of Facility Holding Health Information

To release information from the medical records of _____
Patient Name

To:_____
Print Name/Address of person/organization to which disclosure is to be made

Fax #_____ **Phone #**_____

For treatment dates:_____
SPECIFY DATES---THIS LINE MUST BE COMPLETED

For the following purpose: ☐ **Medical Care** ☐ **Legal** ☐ **Insurance** ☐ **Other (detail)**
_____

Select Portions

- ☐ **Abstract/Pertinent Information**
- ☐ **Lab**
- ☐ **Emergency Room**
- ☐ **Imaging/Radiology**
- ☐ **Nursing Notes**
- ☐ **H & P**
- ☐ **Cardiac Studies**
- ☐ **MD Progress Notes**
- ☐ **MD Orders**
- ☐ **Face Sheet**
- ☐ **Operative Procedure/Report**
- ☐ **Entire Record EXCLUDING HIV testing & chemical dependency**
- ☐ **Entire Record INCLUDING HIV testing & chemical dependency**
- ☐ **Entire Record INCLUDING HIV testing only**
- ☐ **Entire Record INCLUDING chemical dependency only**

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of STEP PEDIATRICS to receive the above information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it.
***When requesting release of information from STEP PEDIATRICS to another facility/person*, I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless STEP PEDIATRICS from all liability and damages resulting from the lawful release of my protected health information. Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.**

_____ _____ _____
Date **Signature of Patient/Parent/Guardian/Conservator** **Relationship to Patient**

IF MORE THAN 5 PAGES
PLEASE MAIL TO:

STEP Pediatrics PA
4800 West Panther Creek, Ste. 100
The Woodlands, TX 77381