



Jollyville Pediatrics
 11851 Jollyville Road, Suite 204
 Austin, Texas 78759
 Phone: 512.219.5550
 Fax: 512.219.5551

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

DELIVERY HISTORY

Delivered at: _____ Obstetrician: _____ Condition at Birth: Wt _____ Ht _____

Premie / Full Term (Circle one) Complications _____ Miscarriages _____

Mo. _____ Cause _____

Feeding – Breast/Formula (Circle one)

FAMILY HISTORY

Please check each member that has the following condition:

Condition	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Asthma						
Diabetes						
Heart Disease						
Cancer						
High Blood Pressure						
Epilepsy						
Kidney Disease						
Hay Fever						
Food Rashes						
Rheumatic Fever						
Tuberculosis						
Other (List)						

Name of brother / sister	Age



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FAMILY PROFILE

Child lives with: ___ Mother ___ Father ___ Stepparent ___ Grandparent ___ Other

Total adults in home: _____ Total children living in home: _____

Primary caretaker for this child: _____ Pets: _____

MEDICAL HISTORY

1. Is the child having any medical problems?
 yes no
2. Prior medical problems? yes no

PHYSICIAN REVIEW

1. Has parent family history / information sheet been reviewed? yes no
2. Has parent provided medical records from previous Physician? yes no

FAMILY MEDICAL / SOCIAL HISTORY

1. What is the overall health condition in the immediate family environment:
 good health poor health
2. Are there any current family issues that might be affecting the child (divorce, death, family problems, etc.)? yes no
3. Are there any current social issues that might be affecting the child? (Smoking/ alcohol, school/daycare, sports, etc.)? yes no
4. Other findings?

INSURANCE INFORMATION

___ Annual Update ___ Insurance Change

How did you hear about our practice? _____

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Mailing Address _____ City/State _____ Zip _____

Birth Date _____ Boy ___ Girl ___ Home # (____) _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED, AND ALL INFORMATION ON THIS FORM MUST BE COMPLETED.

PRIMARY INSURANCE

Subscriber's Name _____ Mailing Address _____

City/State _____ Zip _____ Birthdate _____ Relationship to Patient _____

Soc Sec #: _____ Employer _____ Ins. Member ID # _____

Group # _____ Name of Insurance Co _____ Effective Date _____

SECONDARY INSURANCE (Write none, if applies)

Subscriber's Name _____ Mailing Address _____

City/State _____ Zip _____ Birthdate _____ Relationship to Patient _____

Soc Sec.#: _____ Employer _____ Ins. Member ID # _____

Group # _____ Name of Insurance Co _____ Effective Date _____

Father's Name _____ Birthdate _____

Occupation: _____ SS# _____

Mailing Address _____

City _____ State _____ Zip _____

Home # (____) _____ Work # (____) _____

Mother's Name _____ Birthdate _____

Occupation: _____ SS# _____

Mailing Address _____

City _____ State _____ Zip _____

Home # (____) _____ Work # (____) _____

Emergency Contact _____ Relationship _____ Home# _____ Work# _____

Address _____ City _____ State _____ Zip _____

I understand that, even though I may have some type of insurance and authorize this office to submit charges on behalf of my child, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to my dependent. I am aware that co-payment is required at each visit, and if there is no insurance coverage, payment in full is required for services provided unless prior payment arrangements have been discussed. I will also be responsible for all collection fees, should my account be assigned to a Collection Agency.

Signature _____ Date _____



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OFFICE POLICY – Please Read Carefully

- Co-payment is due at the time of service unless prior arrangements are made. We accept Cash, Personal Check, MasterCard and VISA. If co-payments are not paid, a \$5 service fee will be charged.
- Any balances that are applied to your deductible must be paid in full before the next office visit.
- 24-hour notice of appointment cancellation is required. Multiple no shows will be subject to dismissal.
- In the event that your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- In the event that your health plan applies charges for procedures performed in the office to your deductible, you will be responsible for the charges.
- Our office is not a Medicaid provider. You will be responsible for balances not covered by your primary or secondary insurance

Please sign here that you have read this office policy and agree to it.

Parent or Legal Guardian

Date

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by the physicians and staff associated with Jollyville Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photograph of this form is considered valid as the original.

Parent or Legal Guardian

Date

CONSENT TO SEE PATIENT - WITHOUT PARENT PRESENT

I hereby authorize _____ to bring my child to his/her appointments *Name / Relationship* if I am unable to attend. I understand that medical advice will be relayed to them on my behalf.

Parent or Legal Guardian

Date



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**Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- ? a basis for planning my care and treatment
- ? a means of communication among the many health professionals who contribute to my care
- ? a source of information for applying my diagnosis and surgical information to my bill
- ? a means by which a third-party payer can verify that services billed were actually provided
- ? and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

____ Accepted _____ Denied

Signature **X** _____

Date: _____

Signature of Patient or Legal Representative Witness _____

Date Notice Effective Date or Version _____