Pediatric Gastroenterology Associates of Houston

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐Mr. ☐ Mrs. ☐Ms. ☐Jr. ☐ Sr. ☐Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Patient's Primary Care Physician _____

Marital Status ☐Married ☐Single ☐Divorced ☐ Widowed ☐Legally Separated ☐Other

Social Security Number ____ - ____ - ____ ☐Female ☐ Male Date of Birth ____/____/____

E-Mail Address _____

Phone Number Home _____ ☐Day ☐Evening Work _____ ☐Day ☐Evening

Cellular _____ Pager _____ May we contact you at work? ☐Yes ☐No

Address _____

City, State, Zip (+4) _____

Employment Status ☐Employed ☐Full-Time Student ☐Part-Time Student ☐Retire ☐Self-Employed ☐Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number ____ - ____ - ____ ☐ Female ☐ Male Date of Birth ____/____/____

E-Mail Address _____

Phone Number Home _____ ☐Day ☐Evening Work _____ ☐Day ☐Evening

Address _____

City, State, Zip (+4) _____

Employment Status ☐Employed ☐Full-Time Student ☐Part-Time Student ☐Retire ☐Self-Employed ☐Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name if Insured _____ Relationship to Patient Insured _____

Insurance Company/Phone Number _____ (____) ____ - ____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name if Insured _____ Relationship to Patient Insured _____

Insurance Company/Phone Number _____ (____) ____ - ____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

PEDIATRIC GASTROENTEROLOGY ASSOCIATES OF HOUSTON

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Child's Name *(Last, First, M.I.)* ☐ M ☐ F	**DOB:**
Mother/Guardian:	**Father/Guardian:**

Family doctor (or referring physician):

☐ **PLEASE CHECK BOX FOR ANY ALLERGIES & LIST ALLERGIES (Food or Medications):**

☐ **PLEASE CHECK BOX IF THERE ARE NO KNOWN ALLERGIES.**

Are the child's vaccinations up to date? ____ **YES** ____ **NO**
If no, please list which are not and why: _____

BIRTH HISTORY

Birth weight: _____ **Was child born full term (40 weeks)?** ☐ **YES** ☐ **NO** **If "NO", how many weeks early?** _____

(Circle one) Was child a C-Section or Vaginal delivery? If C-Section, why?

List any previously diagnosed medical problems (if so, list by whom)

PLEASE CHECK "YES" OR "NO" FOR PAST AND PRESENT MEDICAL HISTORY

Has your child had any recent fever or weight loss? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any eye problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any ear, nose or throat problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any respiratory problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any heart problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any stomach or bowel problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any bone or join problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any nerve problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any skin disorders or problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any bone or bleeding disorders or problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any endocrine problems? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any emotional or developmental problems/disorders? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Does your child have any OTHER medical problems not listed? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Has your child ever been HOSPITALIZED? **If yes, please explain** _____	☐ **Yes**	☐ **No**
Has your child ever had any prior SURGERIES? **If yes, please explain** _____	☐ **Yes**	☐ **No**

SOCIAL HISTORY

Who is the LEGAL Guardian/Parent(s) of this child? _____
Relationship(s) to child _____

Is the child adopted or in foster care?	☐ **Yes**	☐ **No**
Are there pets in the home? **If yes, please list** _____	☐ **Yes**	☐ **No**
Does anyone in the house smoke? **If yes, who and how often?** _____	☐ **Yes**	☐ **No**

Type of home: APARTMENT ____ **HOUSE** ____ **MOBILE HOME** ____ **OTHER** ____

_____ (physician initials)

List the child's prescribed drugs and over-the-counter drugs (if "none" leave blank)

Name	Strength	Frequency Taken

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F		Grandmother *Maternal*		
	☐ M ☐ F		Grandfather *Maternal*		
	☐ M ☐ F		Grandmother *Paternal*		
	☐ M ☐ F		Grandfather *Paternal*		

Any family members with bleeding disorders? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with anesthesia problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with kidney problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with heart disease? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with thyroid disease or problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with diabetes? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with cancer? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with lung/respiratory problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with gastrointestinal disease? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with musculoskeletal, bone, or joint disease? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with psychiatric disorders? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No

_____ _____

Signature of person completing this form/relationship to patient Date

Reviewed by provider Date

PEDIATRIC GASTROENTEROLOGY ASSOCIATES OF HOUSTON

PATIENT HIPAA ACKNOWLEDGMENT AND COSNET FORM

Patient Name: _____

Date of Birth: _____

_____(Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__*I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*
__ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

[OPTIONAL ON FORM- REMOVE THIS Section ONLY if NA to your practice]
Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: _____ Date: _____
Name: _____ Date: _____
____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date: _____

Patient Name (Printed): _____ DOB: _____

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