PREMIER pediatrics

PATIENT INFORMATION FORM

Today's date: _____
Who referred you to our practice? _____

Child's Information

Child's Legal Name**:** _____ D.O.B**.:** _____ M / F
Address: _____ Race: _____
City, Zip Code _____ Grade/School: _____

Insurance Company Name: #1 _____ Primary or Secondary
Policy number/Member ID: _____ Group #:_____
Insurance Company Name: #2 _____ Primary or Secondary
Policy number/Member ID: _____ Group #:_____

Mother's Information

Mother's Name: _____ D.O.B.: _____
Address (if different from Patient): _____ SS#: ____ /____ / ____
City, Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
Email: _____

Father's Information

Father's Name: _____ D.O.B.: _____
Address (if different from Patient): _____ SS#: ____ /____ / ____
Same as Patient _____

Phone Numbers: Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
Email: _____

Siblings' Information

Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____

Emergency Contact: _____ **Relation to Patient:** _____ **Phone #:** _____
Pharmacy: _____ **Phone #:**_____

411 Lantern Bend Dr, Ste 235 Houston, TX 77090
P:281-979-2112, F:281-884-3558

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PATIENT HISTORY FORM

Patient's Name: _____ **DOB:** _____

Birth History

Was this child ○ Full Term ○ Preterm ○ Adopted (at what age?) _____ How many weeks at delivery? _____
Type of delivery: ○ Vaginal ○ C-section Reason for C-section _____ NICU stay: O Yes O No
Birth Weight: _____ Length: _____
Did he/she have any problems in the newborn period? _____

Past Medical History

Please check any illnesses your child has had

☐ Anemia
☐ Asthma
☐ Chicken Pox _____ (date)
☐ Recurrent ear infections
☐ Heart Murmur
☐ Pneumonia _____ (date)
☐ RSV/Bronchiolitis/Bronchitis
☐ Recurrent throat infections
☐ Seizures
☐ Eczema
☐ UTI
Other: _____
☐ Allergies
☐ Reflux (GERD)
☐ ADD ☐ ADHD

Sugeries/hospitalizations & dates: _____
Allergies: _____
List all medications: _____

Family History

Please indicate what family member has the following medical problems: Mother(M), Father(F), Brother(B), Sister(S), maternal grandmother(MGM), maternal grandfather(MGF), maternal aunt(MA), maternal uncle(MU), paternal grandmother, (PGM), paternal grandfather(PGF), paternal aunt(PA), paternal uncle(PU)

Anemia	Allergies	Asthma	Bleeding disorder
Bipolar	Cancer	Crohn's disease	Diabetes
Eczema	Emotional problems	Epilepsy	Heart Attack
High blood pressure	High cholesterol	Kidney Disease	Lazy Eye
Lupus	Migraines	Pneumonia	Renal disease
Sickle Cell Trait/Diease	Stroke	Thyroid disease	Tuberculosis
Ulcerative Colitis	Unexplained/Sudden Death	HIV/AIDS	Urinary Reflux

Other conditions not listed _____
Is there anything more you would like us to know about your child? _____
_____

I voluntarily authorize and consent to the child listed below to receive medical care, treatment, vaccines, and diagnostic tests that are deemed necessary by the clinicians and healthcare personnel at Premier Pediatrics of Houston, PLLC while he/she is a patient or until I withdraw my consent. By signing below, I verify that I have the legal right to consent for the patient listed below and that I have read (or they were read to me in a language that I understand) and I agree to follow the policies set forth in the No Show Policy, Immunization Policy, Financial Policy, and Privacy Practices.

Patient Name: _____ Patient's DOB: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

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No Show Policy

A No Show occurs if a patient does not show for a scheduled appointment within 30 minutes **OR** a parent/guardian has not called to cancel a scheduled appointment at least 4 hours prior to the scheduled appointment. All insured and non-insured patients will be charged a $25.00 No Show fee on the second and third missed appointment and dismissal from the practice may result after any subsequent No Shows within a 1 year time frame. The purpose of this policy is not to punish, but rather to improve scheduling opportunities to allow for adequate use of available patient appointment slots and enhanced use of patient, staff and provider time.

- **No Show #1:** The parent/guardian for the patient will be notified of the missed appointment and advised that subsequent missed appointment, without notifying the practice within the cancellation time frame, will result in a $25.00 fee.
- **No-Show #2:** The parent/guardian of the patient will be notified by phone and receive a letter informing them of the two No Show visits and the $25.00 charge that must be paid prior to being seen for another appointment.
- **No-Show #3:** The parent/guardian of the patient will receive a phone call and letter informing them that their account has been flagged for habitual No Shows and that another no-show may result in dismissal from the practice. They will again be charged a $25.00 fee that must be paid prior to being seen for another appointment.

- Patients who No Show as a Double/Triple/Quad Appointment (2, 3, or 4 patients being seen at the same time) will be charged a No Show fee for each child who misses the appointment and may be restricted from scheduling multiples appointments in the future.
- Patients who No Show as a Double/Triple/Quad Well Child Visit appointments will be charged a $25 No Show fee for each child who misses their appointment and NO future multiple Well Child Visit appointments will be scheduled in the future.

The undersigned has read and agrees to the above No Show Policy of Premier Pediatrics of Houston.

_____ _____

Print Name of Parent Signature of Parent

_____ _____

Patient Name Date

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