Stonebridge Pediatrics

Patients' Information

Please enter the information for each child you are registering. If you need more space please ask one of our staff for assistance.

Preferred Name	Last Name	First Name	Date of Birth	Gender	SS #
				M F	
				M F	
				M F	
				M F	
				M F	

Mother's Information

Last Name: First Name: MI:

Address: City: State: Zip Code:

Home Phone: Mobile: Work: Ext.:

E-mail: Comments:

Is this person the person the primary insured? ☐ Yes ☐ No

Do we have permission to discuss health related information with this person? ☐ Yes ☐ No

May we contact this person in case of emergency? ☐ Yes ☐ No

Do we have permission to leave messages about health related information on ☐ Home phone ☐ Mobile pone ☐ Work phone

Father's Information

Last Name: First Name: MI:

Address: City: State: Zip Code:

Home Phone: Mobile: Work: Ext.:

E-mail: Comments:

Is this person the person the primary insured? ☐ Yes ☐ No

Do we have permission to discuss health related information with this person? ☐ Yes ☐ No

May we contact this person in case of emergency? ☐ Yes ☐ No

Do we have permission to leave messages about health related information on ☐ Home phone ☐ Mobile phone ☐ Work phone

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Emergency Contact Information

Please list someone in case of emergency that we may contact if we cannot reach a parent.

Last Name: First Name: MI:

Address: City: State: Zip Code:

Home Phone: Mobile: Work: Ext.:

E-mail: Relationship to child:

Do we have permission to discuss health related information with this person? ☐ Yes ☐ No

May we contact this person in case of emergency? ☐ Yes ☐ No

Do we have permission to leave messages about health related information on ☐ Home phone ☐ Mobile phone ☐ Work phone

Insurance Information

Please enter the information for the person providing insurance coverage.

Last Name: First Name: MI:

DOB: SS#:

Address: City: State: Zip Code:

Home Phone: Mobile: Work: Ext.:

Insurance Co. Name ID #: Group#:

Claims Address City: State: Zip Code:

Member Services/Elegibility & Benefits Phone Number:

Please tell us how you heard about our office:

☐ Postcard ☐ Driving by ☐ Insurance Co. ☐ Advertisement ☐ Internet

☐ Referred by: ☐ Other:

Terms & Conditions

By signing below I am indicating that I understand and agree to the following:

1. I voluntarily give Stonebridge Pediatrics and staff permission to examine and treat my child.
2. I authorize the release of information to my insurance carrier for the purpose of processing claims. I hereby assign medical benefits to Stonebridge Pediatrics.
3. I agree to pay for services rendered unless other arrangements are made prior to the visit.
4. I understand that Vaccine Information Sheets (VIS) required by law to be offered to patient/parent at the time of vaccination are available at www.stonebridgepediatrics.com. I understand that I may request a paper copy of any VIS at any time.
5. I agree that this assignment will remain in effect until revoked by me in writing.

Signature of Patient/Responsible Party:

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office.

Stonebridge Pediatrics

Office Policies

Welcome to the practice! We are honored to provide your child's healthcare. We have a few rules that you should be aware of:

1	It is the parent's/guardian's responsibility to notify the office of any address, phone, or insurance changes. The parent/guardian will be responsible for any service rendered where they have failed to provide current and correct insurance information prior to being seen. Please have your insurance card with you at every visit.
2	Payment is required at the time services are rendered. Insurance co-payments are due at each and every visit. We are required by the insurance company to collect them. If your insurance does not pay for services provided then the parent/guardian is responsible for those charges.
3	If your insurance plan has a deductible and it has not been met for the year, you will be required to pay for the visit in full.
4	Your insurance will be verified prior to the patient being seen. If the insurance cannot be verified you will have the option to reschedule or pay for the visit.
5	We see patients by appointment only. If you are more than 15 minutes late for your appointment you will be asked to reschedule
6	As a courtesy, we will attempt to contact you 1-3 business days before your appointment as a reminder. If for any reason we are unable to contact you, you are still responsible for keeping your appointment.
7	If you cannot keep an appointment, be sure and call at least 24 hours in advance. A broken appointment is a loss to everyone. If you no-show for an appointment, there may be a service charge. Multiple no-shows may result in dismissal from the practice.
8	Appointments must be made for each child examined. If you ask the doctor to examine another child at the time of your appointment you will be charged an additional co-pay for each child seen. This is required by the insurance company.
9	If you have scheduled a well appointment for your child and they are sick at the time of the appointment, they will be seen as a sick visit and the well visit will be rescheduled. This applies to any condition (i.e., ADHD) that requires more than a reasonable amount of time for the physician to effectively manage the condition. The insurance company requires us to do this.
10	There is a $30 fee for returned checks.
11	There will be a $25 charge per child for copies of medical records. Please allow 2 business days for copies to be prepared.
12	You may request a physician's note for excused absences for school or work when your child is seen in our office. However, excuses requested over the phone will be denied. Your child must be seen in our office.
13	Antibiotics will not be prescribed over the phone. If you feel your child might need an antibiotic then they will need to be seen by a physician.
14	If your child is an established patient and has a chronic but stable medical condition requiring ongoing medication (i.e., asthma, allergies, eczema) you may request refills over the phone if they have been seen for the condition in the last 6 months. This does not uniformly apply to ADHD refills. The physician will advise you when the next visit will be required.
15	Refills for ADHD medications must be requested in person by a parent/guardian. No exceptions.
16	If we refer you to a specialist and your insurance requires a referral, we must have 7-10 days advance notice of the appointment date to secure your referral. We must follow insurance company rules to refer to specialists. It is the parent's/guardian's responsibility to make sure we have all the necessary information to make the referral.
17	If you call requesting a referral for a specialist we may require you to come in for a visit before that referral is made. Keep in mind there are many things that your physician can treat without going to a specialist.
18	After-hours coverage is intended for urgent medical problems only. For questions about appointments, billing, referrals, or other issues of a non-urgent nature please wait until the next business day. There may be a service fee for after-hours advice.
19	If there is an emergency, call 911 or take your child to the nearest hospital emergency room. Some local area hospitals include
	a) Medical Central of McKinney, 4500 Medical Center Drive, McKinney, TX 75069, 972-547-8000 b) Presbyterian Hospital of Allen, 1105 Central Expressway, Allen, TX 75013, 972-747-1000 c) Children's Medical Center of Dallas, 7601 Preston Road, Plano, Texas 75024, 469-303-7000
20	Violation of office policies may result in dismissal from the practice.

By signing below I am indicating that I have read and understand and agree to our office policies:

Signature of Patient/Responsible Party: _____

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office.

Stonebridge Pediatrics

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Please list the names of all children you are registering with our practice:

Last Name	First Name	Date of Birth

I have reviewed this office's Notice of Privacy Practices (NPP), which explains how my child's/childrens' medical information will be used and disclosed. I understand that I am entitled to receive a copy of your NPP.

Last name of person completing this form

First name of person completing this form

Your relationship to patient(s)

Signature of Patient/Responsible Party:

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office.

For office use only:

Date attempt was made to obtain signature

Reason signature was not obtained

Today's date

Employee name

Employee signature

Stonebridge Pediatrics

Consent for Use and Disclosure of Protected Health Information

- Our practice reserves the right to modify the privacy practices outlined in the notice.
- I have reviewed this office's Notice of Privacy Practices (NPP), which explains how my child's/childrens' medical information will be used and disclosed. I understand that I am entitled to receive a copy of your NPP.
- Stonebridge Pediatrics may use and disclose protected health information (PHI) about me and my child/children to carry out treatment, payment, and healthcare operations as described in our NPP.
- I have the right to restrict how my child's/childrens' PHI is used and disclosed and that requests to restrict this information must be submitted in writing. I also understand that Stonebridge Pediatrics reserves the right to refuse requested restrictions.
- Stonebridge Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminder cards and patient statements.
- Stonebridge Pediatrics may e-mail me or call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results, and any call pertaining to to my child's/childrens' healthcare.
- This agreement will remain in effect without expiration unless I revoke my consent in writing. I understand that if I revoke my consent that it does not apply to PHI that has already been disclosed for normal, agreed upon practice operations. I also understand that if I refuse to sign this consent or if I revoke an already signed consent Stonebridge Pediatrics will continue to provide treatment to my child.

Please list the names of all children you are registering with our practice:

Last Name	First Name	Date of Birth

Last name of person completing this form | First name of person completing this form | Your relationship to patient(s)

Signature of Patient/Responsible Party:

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office.

For office use only:

Date attempt was made to obtain signature | Reason signature was not obtained

Today's date | Employee name | Employee signature

Stonebridge Pediatrics

Request for Release of Medical Records

Release requested medical records FROM (i.e. your child's previous physician):

Name of Person or Entity from who records are being requested

Street Address

City | State | Zip Code

Phone Number (XXX-XXX-XXXX) | Fax Number (XXX-XXX-XXXX)

Please SEND requested medical records TO:

Name of Person or Entity to receive information

Street Address

City | State | Zip Code

Phone Number (XXX-XXX-XXXX) | Fax Number (XXX-XXX-XXXX)

I hereby authorize the above stated person/entity to release and/or disclose the medical information as indicated below to the healthcare provider, entity or person I have indicated above. Please release and/or disclosure records and information regarding (Parent, please list all your childrens' names and dates of birth for whom we are requesting medical records):

Last Name	First Name	Date of Birth

Duration:	This authorization shall become effective immediately and shall remain in effect until the specified date for one year from date of signature if no date entered.
Revocation:	This authorization may be revoked in writing by the undersigned at any time prior to the release of informationfrom the disclosing party. Written revocation will not affect any action taking in reliance on this authorization before the written revocation was received.
Re-disclosure:	I understand that the requester may not lawfully further user or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.
Specify Records to be Released and/or Disclosed:	Check the box for each type of information is to be released and/or disclosed: ☐ Complete record ☐ Records of care for the following dates: _____ to _____ ☐ Records of care concerning the following conditions: _____ ☐ X-rays and/or laboratory reports (specify): _____ ☐ Mental health records for the following dates: _____ to _____ ☐ Confer verbally about information in my child's medical record with the following person(s) _____ ☐ Other (specify): _____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only (may be left blank): _____

Signature of Patient/Responsible Party:

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office.

Stonebridge Pediatrics

Initial History Questionnaire

NOTE: Please complete a separate form for each child you are registering with our practice.

Household

Please list all those living in the patient's home.

Name	Relationship to Patient	Date of Birth	Health Problems?

Are there other siblings not living in the home? If yes, please list their names, ages and where they live. _____

If mother & father are not living in the home, how often does s/he see the parent(s) not in the home? _____

If one or both parents are not living in the home, how often does s/he see the parent(s) not in the home? _____

Birth History

Birth Weight: _____ pounds _____ ounces Birth Hospital Name: _____

Was the delivery ☐ Vaginal? ☐ Cesarean? If Cesarean, why? _____

Was the baby born ☐ Full-term? ☐ Pre-term? ☐ Post-term? If pre- or post-term, how many weeks gestation? _____

Did mother have any illnesses/problems with pregnancy? ☐ Y ☐ N Explain: _____

Did your baby have any problems after birth? ☐ Y ☐ N Explain: _____

Did baby go home with mother from the hospital? ☐ Y ☐ N Explain: _____

During pregnancy did mother ☐ smoke? ☐ drink? ☐ use street drugs? ☐ take prescription medications?

Please list all medications mother took during pregnancy: _____

General

Do you consider your child to be in good health? ☐ Y ☐ N Explain: _____

Does your child have any serious illnesses or medical conditions? ☐ Y ☐ N Explain: _____

Has your child had any serious accidents? ☐ Y ☐ N Explain: _____

Has your child had any surgery or been hospitalized? ☐ Y ☐ N Explain: _____

Is your child allergic to any medicines or drugs? ☐ Y ☐ N Explain: _____

Stonebridge Pediatrics

Development

Are you concerned about your child's physical development?	☐ Y	☐ N	Explain:	
Are you concerned about your child's emotional development?	☐ Y	☐ N	Explain:	
Are you concerned about your child's attention span?	☐ Y	☐ N	Explain:	

For those children who attend school (this section may be skipped if your child is not in school):

Are you concerned about your child's behavior in school?	☐ Y	☐ N	Explain:	
Are you concerned about your child's academic progress?	☐ Y	☐ N	Explain:	
Has your child ever been repeated a grade?	☐ Y	☐ N	Explain:	
Does your child attend special education classes?	☐ Y	☐ N	Explain:	

Medical

Does your child have or has s/he ever had:

Chickenpox	☐ Y	☐ N	Explain:	
Frequent ear infections	☐ Y	☐ N	Explain:	
Problems with ears/hearing or eyes/vision	☐ Y	☐ N	Explain:	
Nasal allergies	☐ Y	☐ N	Explain:	
Asthma, bronchitis, bronchioloitis, or pneumonia	☐ Y	☐ N	Explain:	
Heart problems or heart murmur	☐ Y	☐ N	Explain:	
Anemia, bleeding problem, or blood transfusion	☐ Y	☐ N	Explain:	
Frequent abdominal pain	☐ Y	☐ N	Explain:	
Constipation	☐ Y	☐ N	Explain:	
Urinary tract infections	☐ Y	☐ N	Explain:	
Bedwetting (after age 7)	☐ Y	☐ N	Explain:	
(For girls) Has she started menstrual periods?	☐ Y	☐ N	Explain:	
(For girls) Are their problems with her menstrual periods?	☐ Y	☐ N	Explain:	
Chronic skin problems (i.e. eczema)	☐ Y	☐ N	Explain:	
Frequent headaches	☐ Y	☐ N	Explain:	
Epilepsy or convulsions	☐ Y	☐ N	Explain:	
Diabetes	☐ Y	☐ N	Explain:	
Thyroid or other endocrine problem	☐ Y	☐ N	Explain:	
Use of alcohol or drugs	☐ Y	☐ N	Explain:	

Please list any additional medical history: _____

Stonebridge Pediatrics

Family History

Have any family memebers had the following:

Deafness	☐ Y	☐ N	Who:	
Nasal allergies	☐ Y	☐ N	Who:	
Asthma	☐ Y	☐ N	Who:	
Tuberculosis	☐ Y	☐ N	Who:	
Heart disease (before age 50)	☐ Y	☐ N	Who:	
High blood pressure (before age 50)	☐ Y	☐ N	Who:	
Anemia	☐ Y	☐ N	Who:	
Bleeding disorder	☐ Y	☐ N	Who:	
Liver disease	☐ Y	☐ N	Who:	
Kidney disease	☐ Y	☐ N	Who:	
Diabetes (before age 50)	☐ Y	☐ N	Who:	
Bedwetting (after age 10)	☐ Y	☐ N	Who:	
Epilepsy or convulsions	☐ Y	☐ N	Who:	
Alcohol abuse	☐ Y	☐ N	Who:	
Drug abuse	☐ Y	☐ N	Who:	
Mental illness	☐ Y	☐ N	Who:	
Mental retardation	☐ Y	☐ N	Who:	
Immune problems, HIV or AIDS	☐ Y	☐ N	Who:	

Please list any additional family history: _____

Signature of Patient/Responsible Party: _____

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office.

Document Submission

You may sign this document electronically through Adobe Acrobat Reader or if you prefer may sign it manually and fax to our office. Please keep in mind the following before submitting your documents:

- Please make sure that you complete all fields to the best of your ability. Please remember to sign all forms prior to submission. You may sign electronically if you plan to submit by e-mail or manually if you plan to print the forms and fax them or bring them to your child's first appointment.
- Please be sure that you complete a separate "Initial History Questionnaire" for EACH CHILD THAT YOU REGISTER. Those documents may be attached separately to your e-mail. Please save each separate "Initial History Questionnaire" with a different name to your hard drive prior to submission.
- If you decide to submit the forms electronically, please click the "Submit by E-mail" button below. It should open your default e-mail program and add it as an attachment. If for some reason this does not work as it should, you can save a copy of your registration documents to your hard drive and e-mail them to register@stonebridgepediatrics.com. Please do not send any other messages to this e-mail address including but not limited to medical questions, billing questions, or nurse questions. Thank you.

Submit By E-mail | Print Form