San Antonio
Pediatric Surgery Associates

Patient Information

Patient Name: _____ Home Phone #: (_____)_____

Address: _____ City:_____ Zip: _____

Date of Birth: _____/_____/_____ Sex: ☐Female ☐Male SS #:_____

Guarantor/Responsible Party

Father's Name: _____ Cell Phone #: (_____)_____

Address: _____ City:_____ Zip: _____

Date of Birth: _____/_____/_____ SS #:_____ e-mail: _____

Employer: _____ Wk Phone #: (_____)_____

Employer Address: _____ City:_____ Zip: _____

Mother's Name: _____ Cell Phone #: (_____)_____

Address: _____ City:_____ Zip: _____

Date of Birth: _____/_____/_____ SS #:_____ e-mail: _____

Employer: _____ Wk Phone #: (_____)_____

Employer Address: _____ City:_____ Zip: _____

Insurance Information

*Primary Insurance Company: _____ ID #:_____ Group #:_____

Insurance Co Phone #:(____)_____ Policy Holder: _____ Relationship to Patient: ☐Child ☐Self ☐Other

*Secondary Insurance: _____ ID #:_____ Group #:_____

Insurance Co Phone #:(____)_____ Policy Holder: _____ Relationship to Patient: ☐Child ☐Self ☐Other

Name of Referring MD/Pediatrician: _____ Phone #: (_____)_____

Address: _____

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

How well do you speak English? _____ Very Well _____ Well _____ Not Well _____ Not At All Pref Lang _____

Ethnicity: Hispanic or Not Hispanic Race: Asian Black White Other _____

_____ _____
SIGNATURE OF PATIENT/GUARDIAN DATE

YOU MUST BE PREPARED TO PAY YOUR COPAY AND DEDUCTIBLE AT THE TIME OF YOUR APPOINTMENT

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AUTHORIZATION FOR OBTAINING AND DISCLOSING PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations

Patient Name:	Birthdate:	Social Security No. (*optional*):

Provider's Name:	Recipient's Name:
Provider's Address:	Recipient's Address:

Provider's Phone #:	Provider's Fax #:	Recipient's Phone #:	Recipient's Fax #:

This authorization will expire on the following (fill in the date or event but not both):
Date: Event:

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record ☐ Intake form ☐ Dictation reports ☐ Laboratory reports		☐ Diagnostic tests ☐ Special test/therapy ☐ Monitoring strips ☐ Itemized bill:		☐ HCFA-1500: ☐ Other: ☐ Other:	

I understand that: I may refuse to sign this authorization and that it is strictly voluntary.
My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken in reliance on this authorization prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
If the requester or receiver is not a health plan, health care provider, health care clearing house or business associate of such health plan, health care provider or health care clearing house are the released information may no longer be protected by federal privacy regulations and may be redisclosed.
I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
I may receive a copy of this form after I sign it.

Section B: The request of PHI is for the purpose of marketing

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Indicate authorized representative's authority to act on the patient's behalf: (check one)

☐ Parent/Legal guardian ☐ Limited Power of attorney

☐ General power of attorney ☐ Other (Please describe):_____

San Antonio
Pediatric Surgery Associates

Pediatric Plastic and Craniofacial Surgery

Peter T. H. Wang, MD, DMD
C. Alejandra Garcia-de Mitchell, MD
4499 Medical Drive, Suite 347
San Antonio, Texas 78229
Phone (210) 615-8757

Please fill-in the following Medical History Sheet to the best of your knowledge.

Referred By:_____Phone Numer:_____

Reason for Visit:_____

Past Medical History

-
-
-
-

Past Surgical History

-
-
-
-

Any problems with anesthesia in the past? Yes or No Explain:_____

_____

_____

Current Medications

-
-
-
-
-

Does the patient have any allergies to medications? Yes No Explain:_____

_____

_____

San Antonio
Pediatric Surgery Associates

Today's date_____

Name_____ Date of Birth_____
Last First M.I.

PLEASE CHECK YES OR NO BY THE CURRENT COMPLAINT OR AILMENT THAT APPLIES TO YOU/CHILD. IF UNSURE, PLACE *A QUESTION MARK.*

GENERAL

YES NO

___ ___ Weight loss greater than 10lbs in last Year
___ ___ Poor Appetite
___ ___ Trouble Sleeping
___ ___ Fever

EYES
___ ___ Glasses/Contacts
___ ___ Loss or Change of Vision
___ ___ Glaucoma or Cataracts

EARS, NOSE AND THROAT
___ ___ Hearing Aids/Hearing Loss
___ ___ Sore Throat/Strep Throat
___ ___ Nose bleeds
___ ___ Recurrent Ear Infections

CARDIOVASCULAR
___ ___ High Blood Pressure
___ ___ Heart Murmur
___ ___ Mitral Valve Prolapse
___ ___ Irregular Heartbeat
___ ___ Previous Heart Attack
___ ___ Chest Pain

RESPIRATORY
___ ___ Shortness of Breath
___ ___ Asthma
If yes, # of times a week you use inhaler? _____
___ ___ History of Tuberculosis
___ ___ Chronic Cough
___ ___ Emphysema
___ ___ COED (chronic obstruction pulmonary disease)
___ ___ History of Apnea

GASTROINTESTINAL
___ ___ Ulcers
___ ___ Nausea/Vomiting
___ ___ Constipation or Diarrhea
___ ___ Vomiting / coughing up blood
___ ___ Hemorrhoids
___ ___ Jaundice
___ ___ Cirrhosis
___ ___ Gallstones

FEMALES ONLY
___ ___ Prior Breast Biopsy
___ ___ Breast Lumps
___ ___ Bloody Nipple Discharge
___ ___ Abnormal Mammogram
Date of Last Mammogram _____
Birth Control Method _____

Do you plan on having any more children? _____YES _____NO

Is there a chance you might be pregnant? _____ YES _____ NO

GENITOURINARY
YES NO
___ ___ Problems Urinating
___ ___ Difficulty starting stream
___ ___ Painful/Burning/Frequent Urination

MUSCULOSKELETAL
___ ___ Abnormal growths/lumps
___ ___ Joint swelling or pain
___ ___ Amputation
What part? _____

SKIN
___ ___ Psoriasis
___ ___ Non-healing crusting of the skin
___ ___ Skin Cancer
If so, where _____

NEURO
___ ___ Blackouts/Fainting
___ ___ Seizures
___ ___ Headaches
___ ___ Problems with speech
___ ___ Confusions

PSYCHIATRIC
___ ___ Prior Counseling
___ ___ Taking medication, for psych. problems
___ ___ Severe Depression

ENDOCRINE
___ ___ Diabetes
___ ___ Thyroid problems

ALLERGY/IMMUNOLOGIC
___ ___ Food Allergies
___ ___ HIV Infection
___ ___ Hepatitis ___A ___B ___C

HEMATOLOGIC/LYMPHATIC
___ ___ Bleeding Disorders
___ ___ Enlarged Lymph Nodes

**Have you ever taken Accutane? If so when? _____
**Do you suffer from dry syndrome? ___yes ___no
**Do you use eye drops frequently? ___yes ___no

_____
MD Signature

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Pediatric Plastic and Craniofacial Surgery

Peter T. H. Wang, MD, DMD
C. Alejandra Garcia-de Mitchell, MD
4499 Medical Drive, Suite 347
San Antonio, Texas 78229
Phone (210) 615-8757 or 615-0068 Fax (210) 615-0076

Authorization for the release of Medical photographs/slides and or videotapes

INSTRUCTIONS:

This is a content document that has been prepared to help inform you concerning permission to take photographs, slides and or videotapes and to use these images for a purpose as defined with this consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your Plastic Surgeon.

INTRODUCTION:

Medical photographs/slides and videotapes may be taken before, during or after surgical procedure or treatment. Consent is required to take such images.

Additionally, patient may consent to release these medical photography / slides and videotapes for stated purpose.

CONSENT TO TAKE PHOTOGRAPH/SLIDES/VIDEOTAPES

I hereby authorize Peter T. H. Wang, MD, DMD, and/or C. Alejandra Garcia-de Mitchell, MD, to take pre-operative, intra-operative and post-operative photograph, slides and/or videotapes. I additionally consent to photopgraph, slides and/or videotapes of my interview.

1). I consent for these photographs to be used with your office to show prospective patients.

2). I consent for these photographs to be used in marketing efforts as examples of Peter T. H. Wang, MD, DMD, and C. Alejandra Garcia-de Mitchell, MD.

_____ _____
(Patient or Patient Representative Signature) Date

_____ _____
(Witness) Date

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4499 Medical Drive, Suite 347 - San Antonio, Texas 78229
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1. _____
2. _____
3. _____
4. _____

THE PATIENT STAFF HAVE MY PERMISSION TO LEAVE MESSAGES CONCERNING TREATMENT (i.e., LAB RESULTS) on my: (Please check all boxes that apply)

___Home Voice Mail or Answering Machine Home Phone number:_____

___Cell phone Cell phone number:_____

___Work Voice Mail Work phone number:_____

___NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____
Print Name of Patient *Print Name of Authorized Representative

_____ _____
Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

____Parent/legal guardian ____Power of Attorney

*Evidence of authority must be provided and on file with the practice.

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Health Insurance Portability and Accountability Act (HIPAA) Consent

General

In seeking medical advice or receiving medical care in this practice Protected Health Information (PHI) will be generated on you (your child). This information includes your medical information (past, present, and future) and personal information such as your name, address and social security number.

This information will be used for the Treatment of your medical condition(s), obtaining Payment from your insurance company and for Healthcare Operations (TPO) within the practice.

Privacy Practice Notice

For a more complete description of how your PHI may be used and disclosed, you may review this practice's "Notice of Privacy Practices". A copy of our notice is available at the reception desk. You may keep the copy of the notice for your records if you like.

Individual Rights

You have the right to revoke this consent in writing, except to the extent that our practice has taken action on reliance of this consent.

You have the right to refuse to sign this consent.

This practice has the right to refuse to treat you if you refuse to sign this consent of if you, at any time, revoke this consent.

Your signature below acknowledges:

- You have read and understand this consent
- You have agreed to have your PHI used by this practice for the purpose of your treatment, to secure payment for your treatment, and for this practice's healthcare operations
- Prior to signing this consent, you were given a copy of this practice's Notice of Privacy Practices
- You are aware that you may now or at any time request restrictions to the use and disclosure of your PHI
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent

_____ _____

Child's Name (please print) Signature of Parent or Legal Guardian

_____

Date