☐ DR. CARLSON ☐ DR. PAYNE ☐ DR. SUREKA

PATIENT REGISTRATION FORM / INFORMACION del PACIENTE

Date of Visit / Feche de Cita: _____

Patient Last Name / Apellido: _____ **First Name / Nombre:** _____ **Date of Birth / Fecha de Nacimento:** _____

Patient Social Security Number / Numero de Social Security: _____ **Gender / Sexo:** ☐ Male ☐ Female

Address / Direccion: _____ **City, State, Zip Code/ Ciudad, Estado, Codigo Postal:** _____

Cell Phone / # de Celular: _____ **Home Phone / # de Domicilio:** _____

Race / Raza:
- ☐ American Indian / Indio Americano
- ☐ Black/African American / Negro/Afroamericano
- ☐ Asian / Asiatico
- ☐ Native Hawaiian or Pacific Islander / Hawaianos Nativos/Isleno del Pacifico
- ☐ White / Caucasico
- ☐ More than one race / Mas de una raza
- ☐ Other / Otros
- ☐ Refuse/Decline / Rehusar

Ethnicity / Etnicidad:
- ☐ Hispanic or Latino / Hispanico/Latino
- ☐ Not Hispanic or Latino / No Hispanico/Latino

Name of Referring Doctor / Doctor Que Lo Recomendo: _____ **Referring Physician Phone / # de Tel:** _____

Referring Physician Address / Direccion: _____ **City, State, Zip Code / Ciudad, Estado, Codigo Postal:** _____

Name of Pediatrician/Family Physician: / Pediatra/Doctor Particular: _____ **Pediatrician/Family Physician Phone / # de Tel:** _____

Pediatrician/Family Physician / Direccion: _____ **City, State, Zip CodeCiudad, Estado, Codigo Postal:** _____

Is the patient allergic to any medication? If so, please list. / Alergias de medicina? _____

PARENT or GUARDIAN INFORMATION / INFORMACION de los PADRES/ESPOSO (A)

Father's Name / Nombre de Padre/Esposo: _____ **Father's Date of Birth / Fecha de Nacimineto:** _____

Father's Social Security Number / Seguro Social #: ____ - ____ - ____

Address / Direccion: _____ **City, State, Zip Code / Ciudad, Estado, Codigo Postal:** _____

Father's Cell Phone / # de Celular: _____ **Father's Home Phone / # de Casa:** _____

Father's Employer / Compania de Trabajo: _____ **Employer Phone / # de Trabajo:** _____

Father's Email Address / Correo Electronico: _____

Mother's Name / Nombre de Madre/Esposo: _____ **Mother's Date of Birth / Fecha de Nacimineto:** _____

Mother's Social Security Number / Seguro Social #: ____ - ____ - ____

Address / Direccion: _____ **City, State, Zip Code / Ciudad, Estado, Codigo Postal:** _____

Mother's Cell Phone / # de Celular: _____ **Mother'sHome Phone / # de Casa:** _____

Mother's Employer / Compania de Trabajo: _____ **Employer Phone / # de Trabajo:** _____

Mother's Email Address / Correo Electronico: _____

*** PARENT BRINGING CHILD FOR APPOINTMENT WILL BE RESPONSIBLE FOR CHARGES / PERSONA QUE TRAIGA LOS NINOS SERA RESPONSIBLE POR LA CUENTA***

PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE /
PAGOS SERAN COLECTADOS EL DIA DE LA CITA AL MENOS QUE ACUERDOS SEAN HECHOS CON ANTICIPO

INSURANCE INFORMATION / INFORMACION de ASEGURANCA

PRIMARY INSURANCE COMPANY / SEGURO PRIMARIO

Name of Insurance / Nombre de Aseguranca: _____ Ins. Phone / # Tel: _____

City, State, Zip / Ciudad, Est., Codigo Postal: _____

Policy Number/Member ID / # de Miembro/Poliza: _____ Group Number / # de Grupo: _____

Insured Last Name / Apellido de Asegurado: _____ Insured First Name / Primer Nombre: _____

Insured Relationship to Patient / Relacion del Asegurado al Paciente: _____

SEGURO SECUNDARIO / SECONDARY INSURANCE COMPANY

Name of Insurance / Nombre de Aseguranca: _____ Ins. Phone / # Tel: _____

Ins. Claims Address / Direccion: _____

City, State, Zip / Ciudad, Est., Codigo Postal: _____

Policy Number/Member ID / # de Miembro/Poliza: _____ Group Number / # de Grupo: _____

Insured Last Name / Apellido de Asegurado: _____ Insured First Name / Primer Nombre: _____

AUTHORIZATION AND RELEASE / AUTORIZACION DE INFORMACION

I hereby authorize and direct my insurance benefits to be paid directly to Texas Pediatric Cardiology Associates. I also authorize the release of any information regarding medical records. As parent/guardian of above patient, I consent to treatment of said patient. I understand I am financially responsible for any fee incurred; this includes fees for medical services not covered by my insurance.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

==========

Yo autorizo mi medico suministrar a mi(s) compania de seguranca(s) y a conseguir pagos directos al medico. Autorizo mi medico distribuir mis archivos medicos. Yo reconosco la responsabilidad de cualquier balance que quede despues de lo que page mi(s) aseguranca(s).

Signed / Firma: _____ ***Date / Fecha:*** _____

Parent/Guardian (if patient is a minor) / Paciente o de Padre/Madre si el paciente es menor de edad

Relationship to Patient / Relacion al Paciente: _____

REVISED: 04-16-14

Please use blue or black ir
when completing this form

PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: _____

Past Medical History:

Mother's Length of Pregnancy: _____ weeks or months (circle one)

Problems during Pregnancy? YES NO (circle one)

Birth Weight: _____

Length of hospitalization after birth: _____

Immunizations up to date? YES NO (circle one)

Previous Hospitalizations? YES NO (circle one) If yes, list: _____

Previous Surgeries? YES NO (circle one) If yes, list: _____

Allergies? (Circle all that apply)

Medicine YES NO (circle one) If yes, list: _____

Seasonal YES NO (circle one) If yes, list: _____

Foods YES NO (circle one) If yes, list: _____

Any Developmental Problems? YES NO (circle one) If yes, list: _____

Family History: (Mark all that apply and tell us if the family member is on the paternal or maternal side.)

History of:	***Family Member:***	***History of:***	***Family Member:***
Born with Heart Defects	_____ Maternal or Paternal?	High Blood Pressure	_____ Maternal or Paternal?
High Cholesterol	_____ Maternal or Paternal?	Sudden Death	_____ Maternal or Paternal?
Heart Attacks/Stroke less than 55yrs	_____ Maternal or Paternal?	Diabetes	_____ Maternal or Paternal?
Heart Rhythm Problems/Pacemakers	_____ Maternal or Paternal?	Seizures	_____ Maternal or Paternal?

Social History:

Patient lives with: Mother Father Stepmother Stepfather (circle all that apply)

_____ brothers _____ sisters Other _____

School: _____ grade

Please list any medications the patient is currently taking:

_____

_____

_____

_____

(continued on back)

REVIEW OF SYSTEMS: Fill in the circle for all that apply. Please note that those items marked with an asterisk (*) may apply specifically to infants.

General	○ Appetite Change ○ Trouble Sleeping ○ *Fatigues Easily	○ Activity Change ○ *Poor Sleeper	○ Fever	○ Irritability ○ *Excessive Crying	○ Lethargy ○ Slow Weight Gain
Eyes	○ Blurred vision ○ Lazy Eye	○ Corrective Lenses ○ Eye Drainage	○ *Eye Redness		
Ears, Nose & Throat	○ Gum Bleeding ○ Tooth Pain ○ *Hearing Problems ○ *Teething	○ Hearing Loss ○ Nosebleeds	○ *Nasal Drainage	○ Nasal Congestion	○ Sleep Apnea ○ Noisy Breathing
Cardio-vascular	○ Chest Pain/ Pressure ○ Fainting ○ *Loss of Consciousness	○ Cool Extremities ○ Fast Heartbeat	○ Color Change ○ Irregular Heartbeat	○ Easy Fatigability ○ Murmur ○ Palpitations	○ Excessive Sweating ○ *Sweating during feeds/sleep
Respiratory	○ Asthma Symptoms ○ Frequent Pneumonia (URI)	○ Chronic Cough	○ Wheezing ○ *Fast Breathing	○ Shortness of Breath with Exercise ○ *Shortness of Breath with Feeds	○ Snoring
Gastro-Intestinal	○ Abdominal Distension ○ *Diarrhea ○ *Feeding Problems	○ Abdominal Pain ○ *Colic	○ Eating Problems ○ Constipation ○ *Jaundice	○ Reflux Symptoms ○ *Blood in Stool	○ Vomiting ○ Nausea ○ *Coughing/ Choking with Feeds
Genitourinary	○ Blood in Urine ○ *Foul Odor in Urine	○ Decreased Urination	○ Frequent Urination		
Musculo-skeletal	○ Bone Deformity	○ Joint Pain	○ Joint Swelling ○ *Swelling Hands/Feet	○ Muscle Aches ○ *Muscle Weakness	○ Scoliosis ○ *Decreased Muscle Tone
Skin	○ Birthmarks ○ *Hemangiomas	○ Cyanosis	○ Rash ○ *Signs of Eczema	○ Nail Changes ○ *Pallor	
Neurological	○ Dizziness ○ *Unusual Movements	○ Headache ○ *Stopping Breathing	○ Hyperactivity	○ Seizures	○ Weakness
Endocrine	○ Excessive Weight Gain	○ Slow Growth ○ *Abnormal Growth	○ Weight Loss	○ Diabetes ○ Change in Periods	○ Thyroid Problems
Hematologic	○ Bleeding Problems	○ Easy Bruising	○ Swollen Glands		
Psychiatric	○ ADD	○ ADHD	○ Depression	○ School Problems	

PEDIATRIX CARDIOLOGY

OUR FINANCIAL POLICY

The physicians and staff here at **Pediatrix Cardiology of North Texas (PCNT)** are concerned about the cost of your healthcare and have taken considerable effort in setting our fees. We assure you that our charges reflect the skill and expertise required for the evaluation and management of your condition. We participate in numerous managed healthcare plans, however, if you have questions regarding our participation in your specific plan, do not hesitate to ask, or contact your insurance provider for clarification. If you have any questions regarding our financial policy or our fees, please feel free to discuss them with our **Billing Office** at **(866) 866-9530**. In accordance with SB1731, upon request, you will be given an itemized statement of charges including an explanation of said charges within 10 business days.

Although we are happy to assist you in submitting and appealing your claim, please understand that your insurance policy is an agreement between you and your insurance carrier. You are responsible for all lawfully incurred expenses whether or not covered by insurance.

At the time services are rendered, your deductibles, co-payment or percentage portion is required. We accept MasterCard, Visa, Discover, American Express, checks, cash or money orders.

For Medicaid or HMO participants, please note: It is your responsibility to provide all necessary coverage information, as well as obtaining prior authorization from your primary care physician. *Failure to provide this information will result in you being financially responsible for all charges incurred.*

Financial Responsibility

I have read, understand, and agree to **PCNT**'s Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to **PCNT** for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **PCNT** to: 1.) Release any information necessary to insurance carriers regarding my and/or my dependents' illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from **PCNT** on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Print Name of Patient	Date
Print Name of Parent/Authorized Representative (if patient is a minor)	Signature (If patient is a minor, Signature of Parent/Authorized Representative)

OBSTETRIX MEDICAL GROUP PEDIATRIX CARDIOLOGY PEDIATRIX MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgement.

If you have any questions about your rights or our privacy practices, please send an electronic message (email) to privacy_officer@pediatrix.com or you may mail a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

Print Name of Patient	Date
Print Name of Parent/Authorized Representative (If patient is a minor)	Signature (If patient is a minor, Signature of Parent/Authorized Representative)

PEDIATRIX
CARDIOLOGY

AUTHORIZATION to RELEASE PROTECTED HEALTH INFORMATION (PHI) 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 (Health Insurance Portability and Accountability Act) authorization. This permission will be considered ongoing until I indicate otherwise in writing.

PHI MAY BE RELEASED TO THE FOLLOWING INDIVIDUALS:

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

___ **Yes** ____ **No** The practice staff has my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff hace my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

- ☐ Home Voice Mail/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

_____ Date

_____ *Print Name of Parent/Authorized Representative (If patient is a minor)

_____ Signature (If patient is a minor, Signature of Parent/Authorized Representative)

**Evidence of authority must be provided and on file with the practice; Authorized Representative's authority to act on the patient's behalf:*

☐ *Parent/Legal Guardian* ☐ *Power of Attorney*