New Patient Registration Form

PATIENT INFORMATION

Name (LAST) (FIRST) (MIDDLE)	
Date of Birth ____/ ____/ ____	□ Female □ Male

RESPONSIBLE PARTY INFORMATION

Name (LAST) (FIRST) (MIDDLE)	
Date of Birth ____/ ____/ ____	□ Female □ Male
Billing Address, City, State, Zip	
Primary Phone (CIRCLE: HOME CELL WORK)	
Secondary Phone (CIRCLE: HOME CELL WORK)	
Other Phone (CIRCLE: HOME CELL WORK)	
E-mail Address	
Relationship to Patient	

EMERGENCY CONTACT INFORMATION

Name (LAST) (FIRST) (MIDDLE)	
Date of Birth ____/ ____/ ____	□ Female □ Male
Primary Phone (CIRCLE: HOME CELL WORK)	
Secondary Phone (CIRCLE: HOME CELL WORK)	
Other Phone (CIRCLE: HOME CELL WORK)	
E-mail Address	
Relationship to Patient	

PEDIATRICIAN INFORMATION

Name	
Group Practice	
Phone Number	

PHARMACY INFORMATION

Name	
Address or Crossroads	
Phone Number	
Does patient prefer tablet or liquid medications?	
Does the patient have any drug allergies?	

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

_____ _____

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

Houston Pediatric Urology

Authorization To Release Medical Information

PATIENT NAME: _____ **DATE OF BIRTH:** _____

CURRENT ADDRESS: _____

HOME PHONE: _____ **ALTERNATE PHONE:** _____

I Authorize Information Released *FROM:*

FACILITY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE/FAX: _____

Please Send My Records *TO:*

FACILITY: HOUSTON PEDIATRIC UROLOGY, P.A.

ADDRESS: 7900 FANNIN SUITE 3700

CITY/STATE/ZIP: HOUSTON, TEXAS 77054

PHONE/FAX: (P) 713-795-5160 (F) 713-795-5132

Purpose of Disclosure: _____

Description:	Date(s)	Description:	Date(s)
☐ All PHI in Medical Record	_____	☐ Imaging/Radiology	_____
☐ History & Physical	_____	☐ Medication Record	_____
☐ Special Tests/Therapy	_____	☐ Discharge Summary	_____
☐ Operation Report(s)	_____	☐ Demographics	_____
☐ Emergency Room Information	_____	☐ Consult Report	_____
☐ Clinical Tests:_____	_____	☐ Other: _____	_____

I understand that:

- I may refuse to sign this authorization and that is strictly voluntary. However, refusal to sign this form will make form invalid.
- I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
- 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 prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requestor or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy Regulations and may be disclosed.
- There may be a reasonable fee to obtain a copy of the information being requested on this form
- I get a copy of this form after I sign it.

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

_____ _____

Signature of Patient/Guardian/ or Personal Representative *Date Signed*

_____ _____

Printed Name of Patient/Guardian/ or Personal Representative *Relationship of Personal Representative to Patient*

Houston Pediatric Urology

CONSENT FOR TREATMENT AND PAYMENT AGREEMENT

I hereby authorize Houston Pediatric Urology, PA, to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly Houston Pediatric Urology, PA, of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work-related injury to my employer and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and/or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor, we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Houston Pediatric Urology, PA, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient/Guardian Initial: _____

MEDICAL LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Houston Pediatric Urology, PA. Patient/Guardian Initial: _____

I request this authorization also apply to all other insurance. Patient/Guardian Initial: _____

I acknowledge that I have been given Houston Pediatric Urology, PA, notice of privacy practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official. Patient/Guardian Initial: _____

RELEASE OF MEDICAL INFORMATION

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. I understand that I may request the individuals to leave the exam room at any time.

Name of Person Authorized To Receive Information	Release information? (Please circle).		Allowed in exam room? (Please circle.)	
_____	Y	N	Y	N
_____	Y	N	Y	N
_____	Y	N	Y	N

** If the , the released information may no longer be protected from re-disclosure.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient or Guardian Signature _____

Patient Date of Birth _____/_____/_____ **Today's Date** _____/_____/_____

Houston Pediatric Urology

New Patient Medical Questionnaire

PATIENT INFORMATION

Name (LAST) (FIRST) (MIDDLE)	
Date of Birth	Gender: □ Female □ Male
What is the reason for the visit?	

BIRTH HISTORY

	Explanation
Did the patient have any abnormal prenatal ultrasounds or other abnormalities during pregnancy?	
Was the patient born full term (≥38 weeks)? If not, how many weeks gestational age?	
Where was the patient born?	
Did the patient spend any time in the NICU? If so, explain	

PAST MEDICAL HISTORY

Does the patient have any medical conditions?	
Has the patient ever been hospitalized?	
Are the patient's immunizations up to date?	
Please list and date patient's surgeries.	
Please list all medications, including OTC, that the patient is taking.	
Does the patient have any drug allergies or intolerance?	

FAMILY HISTORY

	Still Alive & Healthy		Age Now	History of Urologic Problems, Including Bedwetting? If yes, what?
	Y	N		
Mother	□	□		
Father	□	□		
Sibling	□	□		
Sibling	□	□		
Other	□	□		

SOCIAL HISTORY

Grade in school	Who does the patient live with? □ Mother □ Father □ Both □ Other:
Occupation of mother	Occupation of father

Patient Name _____

Houston Pediatric Urology

REVIEW OF SYSTEMS

Is your child having problems with any of the following…

		Y	N	Explanation/Other
GENITOURINARY	Frequent or painful urination, blood in urine, urinary infections, or wetting?			
For males:	Hernias, testicular problems, penile problems, discharge? Specify left or right			
For females:	Labial problems or discharge?			
ALLERGIC/IMMUNOLOGIC	Food allergies, plant allergies, or environmental allergies? AIDS/HIV?			
CONSTITUTIONAL	Recent weight changes, fever, weakness, fatigue, or headaches? Delayed developmental milestones?			
CARDIOVASCULAR	Chest pain, rheumatic fever, rapid heartbeat, high blood pressure, swelling, or dizziness? Heart disease or bleeding problems?			
EARS, NOSE, MOUTH, THROAT	Soreness and/or redness of gums, hoarseness, difficulty with swallowing, head colds, discharges, obstruction, post-nasal drip, sinus pain, or ear aches?			
ENDOCRINE	Thyroid trouble, heat or cold intolerance, excessive sweating, thirst, or hunger?			
GASTROINTESTINAL	Appetite, nausea, vomiting, diarrhea, constipation, indigestion, food intolerance, hemorrhoids, jaundice, or bowel control?			
HEMATOLOGIC	Anemia, easy bruising or bleeding, or past transfusions?			
MUSCULOSKELETAL	Back pain, joint pain, fracture, clubbed feet, spasticity, hypotonia?			
NEUROLOGICAL	Fainting, blackouts, seizures, paralysis, tingling, tremors, or memory loss?			
PSYCHIATRIC	Nervousness, mood swings, insomnia, headache, nightmare, or depression?			
RESPIRATORY	Chest pain, wheezing, cough, difficulty with breathing, asthma, bronchitis, pneumonia, or tuberculosis? Lung disease?			
SKIN	Rashes, dryness, jaundice, or discoloration of skin?			

I have reviewed the Medical Questionnaire with the patient and/or family.

_____

PHYSICIAN SIGNATURE DATE