



1872 N. Lake Forest Dr., McKinney, Texas 75071, T: 972.548.0758, F: 972.548.0425

PATIENT INFORMATION

Patient's Name: _____ Male Female
First Middle Last

Date of Birth: _____ Preferred Phone: _____
Month Day Year (to be used for appointment reminders, etc.)

Patient's Address: _____
Number Street Apartment#

City State Zip Code

Name of Siblings: _____

Billing Address: _____ Billing Name: _____
(If bills should be sent to an address different from the patient's)

RESPONSIBLE PARTY CONTACT INFORMATION:

Mother: Name: _____ Date of Birth: _____ Patient lives with mother: _____

E-mail address: _____

Cell Phone: _____ Work Phone: _____

Father: Name: _____ Date of Birth: _____ Patient lives with father: _____

E-mail address: _____

Cell Phone: _____ Work Phone: _____

How did you find us? Friend _____ Driving by _____ Insurance _____ Advertisement _____ Other _____

Signature below indicates financial responsibility for all charges incurred on this account for any portion of your account not paid in full. This is a legally binding agreement for financial responsibility for collection fees, late charges, and any legal fees for nonpayment of the account. This is also a legally binding agreement for McKinney Pediatrics, P.A. to treat and care for your child, unless otherwise noted. Please note that payment is due at time of service unless prior arrangements have been made and agreed to.

THE PERSON WHO BRINGS THE DEPENDENT CHILD TO THIS OFFICE IS RESPONSIBLE FOR THE BILL.

Responsible Party Signature: _____

Responsible Party Printed: _____ Date: _____

INSURANCE INFORMATION



PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____
GROUP #: _____ SUBSCRIBER #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____ EXT: _____
INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____
CITY: _____ STATE _____ ZIP: _____ BUSINESS PHONE #: _____
POLICY EFFECTIVE DATE: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO
INSURANCE COMPANY: _____ CO-PAY: _____
GROUP #: _____ SUBSCRIBER #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____ EXT: _____
INSURED EMPLOYED BY: _____
BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____
BUSINESS PHONE # : _____
POLICY EFFECTIVE DATE: _____

PARENT/GUARDIAN INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT: _____
DRIVERS LICENSE #: _____ STATE ISSUED: _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

Date: _____

McKinney Pediatrics
 1872 N. Lake Forest Drive, McKinney, Texas 75071

Pediatric Health History

Your child's health is of the utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information is treated confidentially.

Child's Name: _____ Date of Birth: _____ Age: _____ M F
 Mother's Name: _____ Home Phone: _____ Work Phone: _____
 Father's Name: _____ Home Phone: _____ Work Phone: _____
 Child's School: _____ Grade: _____

Previous Physician: _____ Phone: _____ City/State: _____

DRUG ALLERGIES		MEDICATIONS	
Substance	Reaction	Medication Name	Dosage

MEDICAL HISTORY

Please check if the child has ever had any of the following:

	CARDIOVASCULAR	GASTROINTESTINAL	MUSCLE/JOINT/BONE	NOSE/THROAT/CHEST
Anemia	Murmurs	Poor Appetite	Broken Bones	Difficulty Breathing
Asthma	Chest Pain	Bloody/Dark Stool	Sprains	Difficulty Swallowing
Bronchitis	Irregular heart beat	Constipation	Coordination Problems	Frequent Colds
Chicken Pox	EYES	Diarrhea	Posture Problems	Hoarseness
Hepatitis	Crossed or wandering	Excessive Hunger	Pain, weakness or swelling	Mouth-Breathing
Measles	Eye Irritation	Excessive Thirst	GENERAL	Nosebleeds
Rubella	Vision Problems	Nausea	Chills	Persistent Cough
Mumps	HEARING/SPEECH	Rectal Bleeding	Depression	Sinus Problems
Rheumatic Fever	Difficulty Hearing	Stomachaches	Dizziness	Sore Throat
Pneumonia	Earaches	Vomiting	Fainting	Strep Throat
Whooping Cough	Ear Infections	Worms	Forgetfulness	Tonsil Infections
RSV	Speech Problems	GENITO-URINARY	Headaches	Wheezing
DENTAL	Other:	Bedwetting	Loss of Sleep	SKIN
Bleeding Gums		Blood in Urine	Mood Swings	Bruise Easily
Grinding Teeth		Diaper Rash, Persistent	Nervousness	Change in Moles
Sensitivity		Discharge (vagina/penis)	Numbness	Hives
Thumb Sucking		Frequent Urination	Sweating	Rash
Last dental Check Up:		Painful Urination	Tiredness	Scares
Brush, how often?		Unusual Urine Order	Weight Loss/Gain	Sores that won't heal
Floss, how often?				

HOSPITALIZATIONS			INJURIES		
Reason	Date	Hospital, City, State	Serious Injuries/Illness	Date	Outcome

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PRENATAL AND INFANT HEALTH HISTORY

Place of birth:		OB:		Mom's age at birth:	
During pregnancy, which of these conditions did you have? (Please check all that apply)					
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> German Measles	<input type="checkbox"/> Venereal Disease			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Non-Prescription drug use:			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prescription drug use:			
<input type="checkbox"/> Edema/Swelling	<input type="checkbox"/> Protein in Urine	<input type="checkbox"/> Controlled Substance drug use:			
<input type="checkbox"/> Exposure to chemicals or radiation	<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Other:			
<input type="checkbox"/> Fever	<input type="checkbox"/> Urinary Tract Infection				

DELIVERY (Please circle all that apply):

On Time Premature Late Normal Delivery Induced /Prolonged Breech C-Section

Please describe any other complications:							
Birth Weight:		Lbs.		Oz.	Birth Defects:		
Discharge Weight:		Lbs		Oz.	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Transfusion
Length:					Feeding (circle one):		
Age at discharge:					<input type="checkbox"/> Breast	<input type="checkbox"/> Formula	<input type="checkbox"/> Both

FAMILY HISTORY

	Age	General Health		Name	Age	General Health
Father			Sibling			
Mother			Sibling			

Please circle any condition that any of the child's blood relatives have had and their relationship:

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Alcoholism		HIV/AIDS	
Allergies		Kidney Disorder	
Anemia		Lung Disorder	
Arthritis		Mental Disease/Disorder	
Asthma/Emphysema		Mental Retardation	
Birth Defects		Muscular Disorder	
Bone/Joint Disorders		Rheumatic Fever	
Cancer		Seizure/Convulsions	
Diabetes		Sickle Cell Disease	
Epilepsy		Skin Disease	
Eye or Ear Disorder		Stroke	
Genetic Defects		Thyroid Disorder	
Heart Disease		TB	
Hemophilia		Venereal Disease	
High Blood Pressure		Other:	

I acknowledge that the information contained herein is correct to the best of my knowledge.

Signature:		Relationship to patient:	
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HIPAA Acknowledgement

I hereby authorize the release or use of my/my child's individually identifiable health information (protected health information or PHI) and medical information by McKinney Pediatrics in order to carry out treatment, payment, or health care operations.

I understand that I have the right to review the practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and I recognize that I have the right to review such Notice prior to signing this Consent Form.

I further understand that the Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. I understand that if they do make changes to the terms of their Notice of Privacy Practices, I may obtain a copy of the revised notice in writing or requesting a copy from the front desk staff.

I retain the right to request that the Practice further restrict how my/my child's protected health information is released or used to carry out treatment, payment, or health care operations. I understand the Practice is not required to agree to such requested restrictions; however, if the Practice does agree to my requested restriction(s), I'm aware that such restrictions are then binding on the Practice.

Patient Name: _____ Date of Birth: _____
(Please Print Name)

Signed: _____ Date: _____
(Parent/Legal Guardian)



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Advance Practice Nurse Consent for Treatment

McKinney Pediatrics, P.A. has on staff an Advance Practice Nurse to assist in the delivery of Pediatric care.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse for my child's health care needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Patient's Name: _____ Date of Birth: _____

Parent's Signature: _____ Date: _____



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Permission for Medical Care & Release of Information

I, _____ hereby authorize the physicians and staff of McKinney Pediatrics, PA to give the following people information about my child's health and well-being. Also, in my absence, any persons listed below can accompany my child to the office for medical care.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

The following information may be given:

	People listed above	Voicemail
Appointment Time	Yes or No	Yes or No
Test/Lab Results	Yes or No	Yes or No
Medications	Yes or No	Yes or No
Procedures	Yes or No	Yes or No
Any info. not listed above regarding my child's health	Yes or No	Yes or No

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. Until written notification is given, this request will remain valid.

Patient's Name: _____ Date of Birth: _____

Signed: _____ Date: _____

(Parent/Legal Guardian)



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No-Show Policy

McKinney Pediatrics policy regarding "No-Show" is as follows:

- **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your child's appointment and to minimize the need to reschedule your appointment - calling us will help with our time management. Our reminder call system allows for an indication for your need to reschedule, McKinney Pediatrics will accept this notification in lieu of a phone call, if it is after business hours.
- **Late arrivals (more than 15 minutes after scheduled appointment) will be offered the next available appointment.** While we will do all that is possible to accommodate requests, the first-available appointment may or may not be on the same day the appointment was missed.
- **A "No-Show" will be documented in your child's record and is used to track missed appointments.** Three "No-Show" appointments within a six (6) month rolling time period (without calling at least 3 business hours prior to the appointment time) will result in dismissal from McKinney Pediatrics and notification to your insurance carrier. McKinney Pediatrics will NOT send out reminders of no-shows, the courtesy of a phone call is all we ask.
- **Remember: appointments canceled more than 3 business hours prior to when they were scheduled will not incur a "No-Show".**

By signing below you acknowledge notification and understanding of McKinney Pediatrics policy on No-Show appointments.

Signature _____ Date _____



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Patient Portal and Use of Electronic Communications

To better serve our patients, our office has established a Patient Portal for some forms of communication. The Patient Portal is a simple way to access your child's health information online. In addition, the Patient Portal allows you to:

- View and request appointments
- View and print immunization records for school and day care
- Request prescription refills
- Retrieve test/lab results
- View and update your child's demographic information
- View billing statements and balance
- Make secure credit card payments
- Communicate with our office by sending and receiving secure messages

For routine matters that do not require immediate response, please feel free to contact us through the Patient Portal. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is approximately one business day. Should you require urgent or immediate attention, please contact our office directly.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your child's medical record information confidential. Despite our best efforts, due to the nature of electronic communications, third parties may have access to messages. When communicating from work, you should be aware that some companies consider electronic communications corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your electronic communications is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your child's provider, the staff and/or other providers would have access to this information.

Dear Patients,

Our practice is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs, but it will also improve the quality of your care and our ability to communicate with you, our patients.

As part of this program, the government requires us to record the following demographic information about you:

- ▶ Preferred language ▶ Race ▶ Ethnicity ▶ Date of birth ▶ Gender

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential.

You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

McKinney Pediatrics

Please identify your Race from the following CDC-defined options:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> African American | <input type="checkbox"/> Burmese | <input type="checkbox"/> Korean | <input type="checkbox"/> Other Race |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Laotian | <input type="checkbox"/> Pakistani |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Madagascar | <input type="checkbox"/> Polynesian |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Dominica Islander | <input type="checkbox"/> Malaysian | <input type="checkbox"/> Singaporean |
| <input type="checkbox"/> Arab | <input type="checkbox"/> Dominican | <input type="checkbox"/> Maldivian | <input type="checkbox"/> Sri Lankan |
| <input type="checkbox"/> Asian | <input type="checkbox"/> European | <input type="checkbox"/> Melanesian | <input type="checkbox"/> Taiwanese |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Micronesian | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Bahamian | <input type="checkbox"/> Haitian | <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> Tobagoan |
| <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Hmong | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Trinidadian |
| <input type="checkbox"/> Barbadian | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Nepalese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Bhutanese | <input type="checkbox"/> Iwo Jiman | <input type="checkbox"/> Okinawan | <input type="checkbox"/> West Indian |
| <input type="checkbox"/> Black | <input type="checkbox"/> Jamaican | | <input type="checkbox"/> White |

Please identify your Ethnicity from the following CDC-defined options:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Central American | <input type="checkbox"/> Hispanic or Latino/Spanish | <input type="checkbox"/> Mexican | <input type="checkbox"/> South American |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Latin American/Latino, Latino | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Spaniard |
| <input type="checkbox"/> Dominican | | <input type="checkbox"/> Puerto Rican | |