

# Family Information

## About Your Children

First Name	Last Name	MI	Preferred Name	DOB	Legal Sex	Pronouns
				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	
				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	
				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	
				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	
				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	

## About You

Primary Insured Parent or Guardian				Other Parent or Guardian			
Last Name	First Name	MI		Last Name	First Name	MI	
Marital Status	SSN	DOB	/ /	Marital Status	SSN	DOB	/ /
Relationship to Patient				Relationship to Patient			
Employer Name		Occupation		Employer Name		Occupation	
Employer Address				Employer Address			
City	State	ZIP		City	State	ZIP	
Work Phone	Extension	Home Phone		Work Phone	Extension	Home Phone	
Mobile Phone	Email Address			Mobile Phone	Email Address		
Home Address				Home Address			
City	State	ZIP		City	State	ZIP	
Emergency Contact Name		Relationship	Emergency Contact Phone				

I understand that I am financially responsible for all charges not paid by insurance within 60 days. Medical benefits will be assigned and paid to Dr. Anne Pediatrics, if filed by our office.

### Consent for Disclosure of Medical Information

- I understand that health care services received by me or my family through Dr. Anne Pediatrics may be covered by one or more health insurance policies or other health plans.
- I understand that in providing or arranging these health care services, Dr. Anne Pediatrics will learn personal medical information about me and my family. This information may be shared with other healthcare professionals as necessary for the care of the patient.
- I agree on behalf of myself and any minor child named on this form that Dr. Anne Pediatrics may share all medical information with the health plan(s) and that health plan(s) may share all medical information with other persons. However, my agreement is limited to the extent that the sharing of medical information is reasonably necessary for the administration of the health plan(s), including all procedures for quality and cost efficiency.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_



# New Patient Questionnaire

				Date	/	/
<b>Patient</b>	Last Name	First Name	MI	DOB	/	/
<b>Mother</b>	Last Name	First Name	MI			
<b>Father</b>	Last Name	First Name	MI			

## Pregnancy and Birth

- Mother's age at birth \_\_\_\_\_
- Mother had illness during pregnancy? N  Y
- Mother took medications? (not vitamins) N  Y
- Baby born before due date? N  Y   
If Yes, how many weeks early? \_\_\_\_\_
- Baby birth weight \_\_\_\_\_
- Baby have trouble in hospital? N  Y   
if Yes, what kind of trouble?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Physician Notes

## Medical History

- Child has allergies? (food, meds, insects) N  Y
- Child had reaction to vaccine? N  Y
- Child been to hospital? (not birth) N  Y
- Child had serious injury? N  Y
- Child had surgery? N  Y
- Child on regular medication? N  Y   
If Yes to any question above, explain.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7 Date of last checkup \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

8 Date of last dental checkup \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

# New Patient Questionnaire

## Family History

- 1 Child's parents have health problems? N  Y
- 2 Child's sibling, parent, grandparent, aunt/uncle had:
- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Inherited disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Sudden death      |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Heart trouble       |  |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Tuberculosis        |  |
- 3 Have any of your children died? N  Y

## Social History

1 List household members and all siblings

Age	Sex	Relationship	Lives at home?	General Health
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	Y <input type="checkbox"/>	_____

2 List household pets

Kind of animal	Pet lives...		
	Inside <input type="checkbox"/>	Outside <input type="checkbox"/>	Inside & Outside <input type="checkbox"/>
_____	Inside <input type="checkbox"/>	Outside <input type="checkbox"/>	Inside & Outside <input type="checkbox"/>
_____	Inside <input type="checkbox"/>	Outside <input type="checkbox"/>	Inside & Outside <input type="checkbox"/>
_____	Inside <input type="checkbox"/>	Outside <input type="checkbox"/>	Inside & Outside <input type="checkbox"/>
_____	Inside <input type="checkbox"/>	Outside <input type="checkbox"/>	Inside & Outside <input type="checkbox"/>

- 3 Smokers in the child's home? N  Y
- 4 Child attends daycare? N  Y

## Physician Notes

# New Patient Questionnaire

## Feeding and Nutrition

- 1 Concerns with child's appetite? N  Y
- 2 Colic or unusual feeding problem in first three months? N  Y
- 3 During first 12 months, baby was:  
 Breast fed     Bottle fed     Breast and bottle fed

## Review of Systems

- 1 Child had frequent ear infections? N  Y
- 2 Child had eye problems? N  Y
- 3 Child had teeth problems? N  Y
- 4 Child has frequent colds or sore throat? N  Y
- 5 Child had asthma, recurring cough, or pneumonia? N  Y
- 6 Child has heart murmur or other heart trouble? N  Y
- 7 Child has problems with urination? N  Y
- 8 Child has problems with diarrhea or constipation? N  Y
- 9 Child ever had convulsions or seizures? N  Y
- 10 Child had eczema, hives, or other skin condition? N  Y
- 11 Child has been anemic? N  Y

## Safety

- 1 Child lives in:  
 Private house     Apartment     Mobile home     Other
- 2 Temperature of home hot water? \_\_\_\_\_ °F     Don't know
- 3 Home has working smoke alarm on each floor? N  Y
- 4 Child always driven in car seat or using seatbelt? N  Y
- 5 Child wears protective equipment for biking or skating? N  Y

## Physician Notes

Note anything else you think relevant or important for Dr. Anne.

# Consent to Treat

I hereby authorize Anne Georgulas, M.D. and staff to treat the patients named below.

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /
			/ /
			/ /

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Legal Guardian

## Transfer of Consent to Another Party

I hereby authorize the following persons to bring my child for medical attention. I consent to treatment in my absence.

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Legal Guardian

## Consent for Teenage Child to Seek Treatment

I hereby authorize my teenage child to consent to treatment in my absence.

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Legal Guardian

## Release of Information (including lab results)

I hereby authorize the following persons to receive by verbal or written statement information related to the medical condition of the patients named above.

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Legal Guardian

# Authorization for Release of Medical Records

Part 1 of 2

## Parent or Guardian Information

Last Name	First Name	MI
Relationship to Patients Listed Below		

## Patient Information

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /
			/ /
			/ /

For the patients listed above, I hereby **authorize the release of the following records:**

- complete medical record
- immunization record
- drug, alcohol, or substance abuse records      Initial: \_\_\_\_\_
- mental health records (except psychotherapy notes)      Initial: \_\_\_\_\_
- HIV/AIDS information (including HIV/AIDS test results)      Initial: \_\_\_\_\_
- genetic information (including genetic test results)      Initial: \_\_\_\_\_
- other records listed below      Initial: \_\_\_\_\_

You must initial for these records.

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For the patients listed above, I authorize release of the above records for the following **reasons:**

- treatment or continuing medical care
- school
- billing or claims
- legal purposes
- personal use
- insurance
- disability determination
- other reasons stated below

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# Authorization for Release of Medical Records

Part 2 of 2



For the patients and records listed above, **send my records:**

from: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**to: Dr. Anne Georgulas**

150 S. Denton Tap Rd.  
Suite 116  
Coppell, TX 75019

tel: \_\_\_\_\_

tel: 972-304-0091

fax: \_\_\_\_\_

fax: 972-393-0959

## I understand:

This authorization is voluntary. Treatment or payment will not be conditioned upon my signing of this authorization form.

This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_.

That I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Payment for Vaccines

Dr. Anne offers some vaccines for which some insurance companies do not pay. In some cases, insurance companies only reimburse part of the cost of vaccines.

Your child may receive any of the following vaccinations in this office:

DTaP	HIB	IPV	DT (adult)
HBV	DTaP-HIB	MMR	Adult Pneumonia
HBV-HIB	Varivax	Hep A	Menomune
Pevnar	Flu Shot	Rotashield	HPV

In addition, new vaccines, when approved for pediatric use, may be made available by Dr. Anne.

There is no way for us to accurately predict whether or not your insurance company will pay for any vaccine provided to your children.

Dr. Anne will bill your insurance once for vaccines. If your insurance does not pay us at least our cost to purchase the vaccine, you will be responsible for this amount.

## Agreement

I agree to be responsible for the cost of vaccines and their administration costs, if they are not covered by my insurance plan.

## Patient Information

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /
			/ /
			/ /
			/ /

Parent or Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Acknowledgement of Privacy Practices



## Parent or Guardian Information

Last Name	First Name	MI
Relationship to Patients Listed Below		

## Patient Information

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /
			/ /
			/ /

I have had the opportunity to review Dr. Anne's **Notice of Privacy Practices** as posted on the web site [www.DrAnneMD.com](http://www.DrAnneMD.com). This notice explains how my children's medical information will be **used and disclosed**. I understand that **I am entitled to receive a copy** of this document upon request.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian

### Office Use Only

- |   |  |
|---|--|
| <input type="checkbox"/> copy given<br>date _____<br>initials _____   | <input type="checkbox"/> rts<br>date _____<br>initials _____                           |
| <input type="checkbox"/> copy mailed<br>date _____<br>initials _____  | <input type="checkbox"/> dns<br>date _____<br>initials _____                           |
| <input type="checkbox"/> copy emailed<br>date _____<br>initials _____ | <input type="checkbox"/> other _____<br>_____<br>_____<br>date _____<br>initials _____ |

# Acknowledgment of After-hours Paging Policy

Dr. Anne is committed to providing her patients and families **quality medical care every day and every hour** of every day. Telephone care is just one way that we meet that commitment.

Dr. Anne is on-call twenty-four hours a day, seven days a week. You can avoid unnecessary emergency room and urgent care visits. **You can save time and money.**

To page after-hours, follow this procedure:

1. Call the after-hours number, **972-656-9362**.
2. **Wait ten minutes** for a call-back.
3. If you do not receive a call-back **in ten minutes, call again.**

Please remember: **paging is meant for urgent medical needs** that cannot wait until regular office hours.

**Do not page for non-urgent issues.** Examples of non urgent care: medication dosages, requests for appointments, refill requests, or routine medical questions.

**For inappropriate calls to the pager, there will be a \$25 charge.** This is not a covered benefit. The parent or guardian will be responsible for this charge.

This policy is **not meant to discourage you** from paging for urgent medical needs.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian