Family Information

Dr. Anne! Modern Parenting, Classic Healthcare.
www.DrAnneMD.com

About Your Children

First Name	Last Name	MI	Preferred Name	DOB	Legal Gender	Pronouns
				/ /	☐ Male ☐ Female	
				/ /	☐ Male ☐ Female	
				/ /	☐ Male ☐ Female	
				/ /	☐ Male ☐ Female	
				/ /	☐ Male ☐ Female	
				/ /	☐ Male ☐ 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

1. 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.
2. 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.
3. 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 ____________________

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New Patient Questionnaire

	Last Name	First Name	MI	
				Date / /
Patient				DOB / /
Mother				
Father				

Pregnancy and Birth

1	Mother's age at birth	___________	
2	Mother had illness during pregnancy?	N ☐	Y ☐
3	Mother took medications? (not vitamins)	N ☐	Y ☐
4	Baby born before due date? If Yes, how many weeks early? _________	N ☐	Y ☐
5	Baby birth weight		
6	Baby have trouble in hospital? if Yes, what kind of trouble? ___________________________________ ___________________________________ ___________________________________ ___________________________________	N ☐	Y ☐

Medical History

1	Child has allergies? (food, meds, insects)	N ☐	Y ☐
2	Child had reaction to vaccine?	N ☐	Y ☐
3	Child been to hospital? (not birth)	N ☐	Y ☐
4	Child had serious injury?	N ☐	Y ☐
5	Child had surgery?	N ☐	Y ☐
6	Child on regular medication?	N ☐	Y ☐

If Yes to any question above, explain.

____

____

____

____

7	Date of last checkup	______/______/______
8	Date of last dental checkup	______/______/______

Physician Notes

150 S. Denton Tap Rd. #116, Coppell, TX 75019 | **tel** 972–304–0091 | **fax** 972–393–0959 | DrAnneMD.com

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New Patient Questionnaire

Family History

1 Child's parents have health problems? N ☐ Y ☐

2 Child's sibling, parent, grandparent, aunt/uncle had:

☐ Asthma ☐ High blood pressure ☐ Inherited disease

☐ Allergies ☐ High cholesterol ☐ Sudden death

☐ Cancer ☐ Heart trouble

☐ Diabetes ☐ 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 ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________
______	M ☐ F ☐	__________	Y ☐	______________

2 List household pets

Kind of animal	Pet lives...		
______________	Inside ☐	Outside ☐	Inside & Outside ☐
______________	Inside ☐	Outside ☐	Inside & Outside ☐
______________	Inside ☐	Outside ☐	Inside & Outside ☐
______________	Inside ☐	Outside ☐	Inside & Outside ☐

3 Smokers in the child's home? N ☐ Y ☐

4 Child attends daycare? N ☐ Y ☐

Physician Notes

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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 ☐

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

Physician Notes

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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

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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.

____

____

____

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

____

____

____

Page 2 →

Authorization for Release of Medical Records

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Part 2 of 2

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

from: ______________________________
____
____

tel: ______________________________
fax: ______________________________

to: Dr. Anne Georgulas
150 S. Denton Tap Rd.
Suite 116
Coppell, TX 75019

tel: 972–304–0091

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!
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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
Prevnar	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 _______________

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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. 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

☐ copy given
date ________
initials ________

☐ copy mailed
date ________
initials ________

☐ copy emailed
date ________
initials ________

☐ rts
date ________
initials ________

☐ dns
date ________
initials ________

☐ other ________________
____
____
date ________
initials ________

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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