www.bluefishmd.com

We are thrilled to have you consider us as your pediatric provider. To ensure that our office meets your expectations we would like to tell you a little bit about our practice. All of our doctors practice evidence-based medicine. Here are some relevant examples of what to expect:

- We adhere to the American Academy of Pediatrics (AAP) recommended vaccine schedule.
- We are judicious about the use of antibiotics and will prescribe them when appropriate. For example, we do not prescribe antibiotics for a viral infection such as the common cold. For the child's safety, we do not call out antibiotics over the phone without a proper examination.
- We do not utilize cough and cold medications, as there is no supporting evidence for their use in the pediatric population.
- We are judicious about the use of radiologic and laboratory tests. Most diagnoses can be made with a thorough history and physical exam.

Our goal is to be the best resource possible for your children's healthcare needs by empowering you with relevant and up-to-date medical information, so that together we provide the best care for your children.

New Patient Application Form

The doctors of Blue Fish Pediatrics have decided to restrict the size of our practice to continue to provide the best quality of care for our patients. The information on this form will be used to that end. After filling out the application, return the form via email, fax, or mail.* You will be notified when we are able to accommodate new patients. Please continue to see your current pediatrician until that time.

*Please fill out **all** fields below.*

Mother's Name: ______________________ **Mother's DOB**

Baby's Name: ______________________ **Baby's Due Date:** ____________

(or) Child's Name: ______________________ **(or) Child's Date of Birth:** ____________

Phone ______________________

Email Address: ______________________

Insurance Plan: ______________________ PPO HMO

(Important: write out **full plan name and ID number**, e.g., *Aetna Select Open Access W123456789*)

Sibling Name: ______________________ **Date of Birth:** ____________

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Sibling Name: ______________________ **Date of Birth:** ____________

Preferred Practice:

Preferred Physician:

Do you plan on following the standard American Academy of Pediatrics immunization schedule, which Blue Fish recommends?**

Are any other family members existing patients at Blue Fish Pediatrics?

How did you hear about Blue Fish? (Please try to limit to 200 characters)

Submit forms to: bluefishkaty@bluefishmd.com or 23960 Katy Fwy, Suite 150 Katy, TX 77494 or 281.347.0081 (fax)

*Note: Submission of a New Patient Application does not guarantee acceptance into the practice. For more information, please contact our office at 281.347.0080.

**The American Academy of Pediatrics immunization schedule can be found at their website http://www2.aap.org/immunization/