

BLUE FISH

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Understanding Our Registration Forms

Thank you for choosing Blue Fish Pediatrics. To register a new patient, please fill out all of the following forms. In order to minimize wait time at your initial office visit, please have all forms completed, signed, and dated before you arrive at the office.

Below is a brief explanation of each form you will be filling out.

New Patient Registration

This form records general and health insurance information about the patient.

Patient Medical History Questionnaire

This form records the medical background of the patient and blood relatives.

Acknowledgement of Review of Notice of Privacy Practices

This form is an acknowledgment that you have read and understand our Notice of Privacy Practices.

Texas Department of State Health Services Immunization Registry (ImmTrac)

This form allows the Texas Department of State Health Services (DSHS) to have an electronic copy of your child's immunization records. If you consent and you ever lose your child's immunization records, DSHS can replace them for you. If you *do not consent*, please notify the front office staff.

Texas Vaccines for Children (TVFC) Disclaimer

This form is a disclaimer stating that your child is not qualified for TVFC and that the parent/guardian is responsible for all costs associated with vaccinations. *If your child is not qualified for TVFC, please sign and date.*

Texas Vaccines for Children Form (TVFC) Patient Eligibility Screening Record

This form determines whether your child is eligible for TVFC. *If your child is qualified for TVFC, please sign and date.*

Health Insurance Portability and Accountability Act (HIPAA) Authorization

This form explains the privacy rights of the patient's medical records.

If you need any assistance filling out these forms, please contact our office. If it is after hours, please leave a message and a receptionist will contact you the following business day.

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Patient Registration

Child's Name: _____ **Date of Birth:** _____

First/Middle/Last

mm/dd/yyyy

Gender: Male Female

Street Address: _____

City, State Zip Code: _____ Telephone: _____

Who referred you to our office?

Demographic Information

Race: American Indian Asian Black or African American Hispanic or Latino White Other: _____ Decline to Answer

Preferred Language: English Spanish Korean Japanese Other: _____ Decline to Answer

Parent(s) / Guardian Information

Father's Name: _____ **Mother's Name:** _____

Date of Birth: _____ Date of Birth: _____

Social Security #: _____ Social Security #: _____

Employer Name: _____ Employer Name: _____

Employer Address: _____ Employer Address: _____

Occupation: _____ Occupation: _____

Home Phone: _____ Home Phone: _____

Cellular Phone: _____ Cellular Phone: _____

Work Phone: _____ Work Phone: _____

Email Address: _____ Email Address: _____

Siblings: Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Do they attend this office? Yes No If no, do you plan to bring them to this office? Yes No

Emergency Contact Name: _____ Phone: _____

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Blue Fish Pediatrics, LLP for services rendered by its physicians in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. Any services rendered outside of the clinic, i.e. lab work, blood tests, x-rays etc., that are not covered by insurance will be my financial responsibility.

Authorization to Release Information

I hereby authorize the physicians of Blue Fish Pediatrics, LLP to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient Name (Please Print) _____ Date _____

Parent/Guardian Name (Please Print) _____ Signature _____

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PEDIATRICS

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Patient Name: _____ DOB: _____ Completed by: _____ Relation: _____

PREGNANCY & BIRTH		Mother's age at pregnancy?	FAMILY MEDICAL HISTORY								
Any illnesses during pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anemia/Blood Dis Asthma Mental Retardation Drug Problem Alcoholism Cancer Aids Cystic Fibrosis Musc. Dystrophy Tuberculosis Arthritis Epilepsy / Seizures Heart Disease High Blood Pressure Cholesterol Problem Migraine Sudden Infant Death Birth Defects Early Deafness Diabetes								
Medication during pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO (exclude vitamins & iron)											
<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs – during pregnancy?											
At birth, how many gestational weeks old was your child? (e.g. term = 40 weeks)											
Type of delivery?	Birth Weight:	Breech?:									
Complications? <input type="checkbox"/> YES <input type="checkbox"/> NO		Apgar:									
Problems with baby at birth? Breathing: <input type="checkbox"/> YES <input type="checkbox"/> NO Jaundice: <input type="checkbox"/> YES <input type="checkbox"/> NO											
Other:											
Pass Hearing Screen? <input type="checkbox"/> YES <input type="checkbox"/> NO		Mother's Blood Type:									
Were you ever told baby was breech in the third (3 rd) trimester? <input type="checkbox"/> YES <input type="checkbox"/> NO											
PAST MEDICAL HISTORY OF CHILD:		Allergic reactions? Medicine: <input type="checkbox"/> YES <input type="checkbox"/> NO	Aids								
Food: <input type="checkbox"/> YES <input type="checkbox"/> NO Animals: <input type="checkbox"/> YES <input type="checkbox"/> NO Insect Bites: <input type="checkbox"/> YES <input type="checkbox"/> NO			Cystic Fibrosis								
Medications taken on a regular basis? (exclude vitamins)			Musc. Dystrophy								
			Tuberculosis								
Immunizations – up to date? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have records? <input type="checkbox"/> YES <input type="checkbox"/> NO			Arthritis								
Hospitalizations – (when-where-why?)			Epilepsy / Seizures								
			Heart Disease								
Surgeries (when-where?)			High Blood Pressure								
			Cholesterol Problem								
	YES	NO	YES	NO	YES	NO	Migraine				
Red Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	German Measles (3 day)	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Infant Death		
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects		
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Early Deafness		
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Hives	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>	DEVELOPMENT & BEHAVIOR		
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Infections	<input type="checkbox"/>	<input type="checkbox"/>	Problems with vision	<input type="checkbox"/>	<input type="checkbox"/>	Age at which child:		
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Sat alone:	Walked:	Bicycled:
									Toilet trained:	Used sentences:	
FEEDING & NUTRITION		Food Allergies:	Development compared to other children?								
Appetite usually good? <input type="checkbox"/> YES <input type="checkbox"/> NO											
Colic or feeding problems during the first 3 months? <input type="checkbox"/> YES <input type="checkbox"/> NO			Grade in school:								
Breast fed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of months?		Problems in school? <input type="checkbox"/> YES <input type="checkbox"/> NO								
Formula? <input type="checkbox"/> YES <input type="checkbox"/> NO	Current brand?										
Vitamins? <input type="checkbox"/> YES <input type="checkbox"/> NO	Brand?	Flouride? <input type="checkbox"/> YES <input type="checkbox"/> NO	Learning problems? <input type="checkbox"/> YES <input type="checkbox"/> NO								
			Getting along with other children?								
			<input type="checkbox"/> YES <input type="checkbox"/> NO								
FAMILY PROFILE		Parents <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Behavior problems? <input type="checkbox"/> YES <input type="checkbox"/> NO								
Father's Age?	Highest school grade?	Health?	Bad Habits? <input type="checkbox"/> YES <input type="checkbox"/> NO								
Mother's Age?	Highest school grade?	Health?	Bedwetting? <input type="checkbox"/> YES <input type="checkbox"/> NO								
		(List child's brothers, sisters, and their ages)	Nail biting? <input type="checkbox"/> YES <input type="checkbox"/> NO								
			Sleeping? <input type="checkbox"/> YES <input type="checkbox"/> NO								
			Hobbies / sports?								
			Use of street or illegal drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO								
SYNOPSIS											



(Please print clearly)

Child's First Name Child's Middle Name Child's Last Name

Child's Date of Birth *Children younger than 18 years old only. Child's Gender: Male Female Telephone

Child's Address Apartment # Email address

City State Zip Code County

Mother's First Name Mother's Maiden Name

Form with checkboxes for Race (select all that apply) and Ethnicity (select only one).

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2").

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group - MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Signature lines for Parent, legal guardian, or managing conservator, including fields for Printed Name and Date.

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request.

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider. Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac DC Texas Department of State Health Services • ImmTrac2 Group - MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2 Please enter client information in ImmTrac2 and affirm that consent has been granted. DO NOT fax to ImmTrac2. Retain this form in your client's record.

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Texas Vaccines for Children (TVFC) Disclaimer

As a service to our patients, our office participates in the Vaccines For Children (VFC) program, which provides vaccines at no charge for those patients who meet the program's eligibility requirements.*

A patient who meets any one of the following requirements is eligible and automatically **qualifies** for the VFC program:

- is enrolled in Medicaid
- is enrolled in Children's Health Insurance Plan (CHIP)
- does not have health insurance
- is underinsured (has health insurance that DOES NOT pay for vaccines**)
- is an American Indian
- is an Alaskan Native

** Overseas traveler's insurance policy holders (e.g. AIU) are considered underinsured.

If your child meets any of the requirements listed above, please complete, sign, and return the TVFC Patient Eligibility Screening Record to our front office staff instead of this disclaimer form. **The TVFC Patient Eligibility Screening Record form must be completed and signed for EACH child that is eligible for the VFC program.**

If your child **DOES NOT** meet any of the requirements listed above, please sign below and return this disclaimer form to our front office staff.

Please be aware that if your child does not meet the VFC requirements and your insurance does not cover the cost of the vaccination(s), you will be responsible for payment.

There are 4 public health clinic locations in the city of Houston that provide all necessary vaccinations for a nominal fee. Please let us know if you need this information.

Disclaimer

I have read and understand the VFC information above. By signing below, I acknowledge that my child is **not qualified** for the Texas Vaccine for Children (TVFC) program.

Full Name of Child (PLEASE PRINT)

Name of Parent / Guardian (PLEASE PRINT)

Signature of Parent / Legal Guardian

Date

Texas Vaccines for Children Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: _____
Last Name
First Name
MI

2. Child's Date of Birth: ____ / ____ / _____

3. Parent, Guardian, or Individual of Record: _____
Last Name
First Name
MI

4. Primary Provider's Name: _____
Last Name
First Name
MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. *If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC eligible children.*

**** Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC Program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*



Patient Name: _____
Patient DOB: _____

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HIPAA: Authorization of Use and Disclosure of Protected Health Information

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Blue Fish Pediatrics (“BFP”)?
(Please check all that apply)

Cell Phone Primary Telephone Secondary Telephone
 Regular Mail Email Fax Machine

Other: _____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at BFP? (Check one)

Yes No N/A

If “No,” how else may we contact you regarding this information?

Please list any other restriction regarding messages or reminders about your healthcare:

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the “Notice of Privacy Practices” and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your protected health information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to BFP of your decision to revoke the authorization. You have the right to request restrictions on use or disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:

HIPAA Authorization (page 2)

Use and Disclosure of Information:

___ I authorize the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at BFP.

___ I do not authorize the following information to be disclosed to any other parties except to me as the patient (please specify):

Persons Authorized to Receive Information:

The following health information and medical treatment BFP collects or receives about you may be disclosed to the following authorize persons to be obtained and received:

Name of person / relation / organization

Name of person / relation / organization

Expiration Date of Authorization

This authorization is effective through ___/___/_____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to BFP. You should contact the office manager to terminate this authorization.

Potential for Re-Disclosure

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (print or type)

Signature of Patient (print or type)

Signature of Patient Representative (print or type)

Relationship of Patient Representative to Patient (print or type)

Patient Name: _____

Patient DOB: _____

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

**MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION**

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth
------------------------------------	---------------

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHiE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.**

Official Use Only:

