BLUE FISH
PEDIATRICS

PATIENT REGISTRATION

Patient Name (First, Middle, Last)	Sex	Date of Birth
	○ M ○ F	

Preferred Pharmacy Name	Pharmacy Street Address	Pharmacy Phone Number

	Legal Guardian #1	Legal Guardian #2
Name (First, Middle, Last)		
Date of Birth		
Relationship to Patient(s)	○ Parent ○ Grandparent ○ Step Parent ○ Other ______________	○ Parent ○ Grandparent ○ Step Parent ○ Other ______________
Home Address	______________________________ Street Address ______________ City ________ State ____________ Zip Code	______________________________ Street Address ______________ City ________ State ____________ Zip Code
Preferred Phone Number		
Email Address		
Preferred Language	○ English ○ Other ________________	○ English ○ Other ________________

If parents are divorced, separated, or unmarried, please complete section:

Which parent does the child primarily reside with?___________________________________

If there are any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment, **please provide a copy of any legal paperwork that supports this restriction.**

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MEDICAL HISTORY

Is there a family history of any of the following:

	NO	YES	If Yes, What Condition?	If Yes, Which Family Member?
Cardiovascular				
Gastrointestinal				
Endocrinology				
Neurological				
Musculoskeletal				
Dermatological				
Respiratory				
Mental Health				
Other				

Does the child have any allergies? ◯ No ◯ Yes (List below)

Food Allergies	Medication Allergies	Environmental Allergies

Has the child had any surgeries or hospitalizations? ◯ No ◯ Yes (List below)

Date	Reason

Please list any current medications ◯ N/A

Medication	Dosage	Frequency of Use	Duration?
			◯ Long Term ◯ Temporary
			◯ Long Term ◯ Temporary

Does the child have any chronic conditions? ◯ No ◯ Yes (List below)

Date of Diagnosis	Condition

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DISCLOSURE OF HEALTH INFORMATION

Blue Fish Pediatrics provides well check-up appointment reminders through text messages to the primary contact number on file. Please indicate the primary contact person for your household below.

Name (First, Middle, Last)	Cell Phone Number

Disclosure of Health Information:

◯ I authorize the following persons (18 years or older) to seek medical care for my child(ren) in my absence. This includes consenting to treatments such as vaccines, medications, labs, and both well and sick care. Additionally, I authorize the individuals listed below to receive all health information related to appointments, treatments, and any other matters pertinent to my child(ren)'s healthcare. Blue Fish Pediatrics may disclose health information and medical treatment details to these authorized individuals.

◯ I **do not** authorize the above information to be disclosed to any other parties except to their parents/legal guardians **(Do Not Complete Table Below)**

Name (First, Middle, Last)	Date of Birth	Cell Phone Number	Relationship to Patient(s)

Would you like to designate the individual(s) listed above as an emergency contact for your children?

◯ Yes ◯ No (please list emergency contact below)

Name (First, Middle, Last)	Date of Birth	Cell Phone Number	Relationship to Patient(s)

Signature____________________________ Date ____________________________

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PRACTICE POLICIES

Please read each policy carefully and initial where indicated. For more details, scan the corresponding QR code. By initialing, I confirm my agreement to follow the outlined policies.

Vaccine Policy: At Blue Fish Pediatrics, we follow the American Academy of Pediatrics (AAP) recommended vaccine schedule and encourage all families to stay on this recommended timeline.

Initial ___________

Audio/Video Recording Policy: Blue Fish Pediatrics is committed to protecting the privacy of our patients, families, and staff members. Please refrain from taking any photographs or making any recordings in our patient care areas.

Initial ___________

Communication Preference Policy: We encourage parents to sign up for our patient portal through the Healow app to access portions of the patient's medical record. Appointment reminders are done via text message.

Initial ___________

Patient Financial Responsibility Agreement: This agreement outlines the patient's responsibility for payment of services rendered, including co-pays, deductibles, and any balances not covered by insurance.

Initial ___________

Notice of Privacy Practice: This document explains how a patient's health information will be used and disclosed.

Initial ___________

Missed Appointments Policy: This policy explains the importance of attending scheduled appointments and the potential penalties for missed appointments without adequate notice.

Initial ___________

Texas Vaccines for Children (TVFC) Disclaimer: This form is a disclaimer stating whether or not your child qualifies for TVFC and that the parent/guardian is responsible for all costs associated with vaccinations if they do not qualify.

Initial ___________

Welcome Guide: Understanding Our Policies: This explains Blue Fish Pediatrics' policies regarding office visits.

Initial ___________

I have reviewed each policy and agreement above and confirm that I've received the necessary resources and understand the provided information.

Signature______________________________ Date ______________________________

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

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

Child's Date of Birth (mm/dd/yyyy) ____/____/________ Child's Gender: ☐ Male ☐ Female

Telephone ______ - ______ - ______ Email address ____________

Child's Address ____________ Apartment # / Building # ____________

City ____________ State ______ Zip Code ______ County ____________

Mother's First Name ____________ Mother's Maiden Name ____________

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code § 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 ImmTrac2. Once in ImmTrac2, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction; a physician, or other health care provider legally authorized to administer vaccines, for treating the child as a patient; a state agency having legal custody of the child; a Texas school or child-care facility in which the child is enrolled; and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2. A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder. For more information, see Texas Health and Safety Code § 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

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

Parent, legal guardian, or managing conservator:

Printed Name ____________ Signature ____________ 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. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

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

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • https://www.dshs.texas.gov/immunize/immtrac/

Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347