

Is there a family history of any of the following:

	NO	YES	If Yes, What Condition?	If Yes, Which Family Member?
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>		
Endocrinology	<input type="checkbox"/>	<input type="checkbox"/>		
Neurological	<input type="checkbox"/>	<input type="checkbox"/>		
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>		
Dermatological	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>		
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

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

Food Allergies	Medication Allergies	Environmental Allergies
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Date	Reason
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Please list any current medications N/A

Medication	Dosage	Frequency of Use	Duration?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Long Term <input type="radio"/> Temporary
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Long Term <input type="radio"/> Temporary

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

Date of Diagnosis	Condition
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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 _____

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, Middle Name, Last Name, Date of Birth, Gender, 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) and Ethnicity (select only one) checkboxes

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...

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...

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...

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.

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