Entirely Kids Pediatrics, PLLC
5575 Warren Parkway, Suite 116, Frisco, TX 75034
Phone: 469-425-3600 Fax: 469-425-3599
www.entirelykidspediatrics.com

New Patient Registration

Today's Date: ____________________ How did you hear about us? __________________________

Patient's Legal Name: ____

(First) (Middle) (Last)

Date of Birth: ______________ Age: _______ Gender: ___M ___F

Address:__________________________________ City/State: _______________________Zip: ___________

Primary Phone:_____________________________

Ethnicity: _________________ Race: __________________Preferred Language: __________________

Custodial Parent: ____Mother ____Father ____ Both Other: _______________________

Contact #1 Legal Name: ____________________________ Relation to patient:__________________________

Date of Birth: _______________________________ SSN: __________________________

Address (if different from patient's): ____

Primary Phone: __________________ Cell Phone: __________________ Work Phone: __________________

Email Address: ______________________________ Employer: _____________________________

Preferred Method of Contact for (please circle one for each):

Appointment Reminders: Home phone/ Work phone/ Cell phone/ Email

Recall Notices: Home phone/ Work phone/ Cell phone/ Email

General Practice Notices: Home phone/ Work phone/ Cell phone/ Email

Contact #2 Legal Name: ____________________________ Relation to patient:__________________________

Date of Birth: _______________________________ SSN: __________________________

Address (if different from patient's): ____

Primary Phone: __________________ Cell Phone: __________________ Work Phone: __________________

Email Address: ______________________________ Employer: _____________________________

Preferred Method of Contact for (please circle one for each):

Appointment Reminders: Home phone/ Work phone/ Cell phone/ Email

Recall Notices: Home phone/ Work phone/ Cell phone/ Email

General Practice Notices: Home phone/ Work phone/ Cell phone/ Email

Emergency Contact Name: ____

Relation to patient: ______________________ Phone: _____________________

Additional siblings that will be our future patients:

Sibling Name: ______________________ DOB: ______________ Gender: ___M ___F

Sibling Name: ______________________ DOB: ______________ Gender: ___M ___F

Sibling Name: ______________________ DOB: ______________ Gender: ___M ___F

Please list any additional adults who will be allowed to bring patient to appointments and consent for treatment:

Name: ___________________________ Relation: ______________ Phone: __________

Name: ___________________________ Relation: ______________ Phone: __________

Name: ___________________________ Relation: ______________ Phone: __________

Insurance Information

Policy Holder's Name: ______________________ Relation to patient: _____________

Date of Birth: _________________________ SSN: ______________________

Name of Primary Insurance Company: _____________________________________

Policy ID number: ______________________ Group Number: ________________

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Patient Health History

Patient's Name: ______________________________ DOB: __________ Gender: _______

Current Medications: ____

Allergies: ____

Medical History

Patient's Past Medical History	Check One: Yes	No	Additional Details:
Allergies/Immunological Disorder			
Behavioral/Developmental Disorder			
Blood/Lymph Disorder			
Cancer			
Cardiovascular Disorder			
History of Chickenpox			Date:
Diabetes			
Ear, Nose, Throat Disorder			
Endocrine/Metabolic Disorder			
GI Disorder			
GU/Renal Disorder			
Musculoskeletal Disorder			
Neurologic Disorder			
Respiratory Disorder			
Skin Disorder			
Other Medical History			

Birth History

Place of Birth: ______________________ Weeks of Gestation: ______________

Vaginal: ___ C-section: ___ Birth Weight: ____________ Length: ____________

Complications during pregnancy: ______________________________

Complications after delivery: ______________________________

Hepatitis B received at birth: ___Yes ___No Passed Newborn Hearing Screen? ___Yes ___No

PKU/Metabolic screening done at hospital? ___Yes ___No

Past Surgical/Hospitalization History

Has the patient ever been hospitalized? ___Yes___No

If yes, please provide date and reason for hospitalization: ______________________________

Has the patient had any surgeries? ___Yes___No

If yes, please provide date and type of surgery: ______________________________

Family Medical History

Family Health History	Check One: Yes	No	Please list family member and details below:
Allergies/Immunological Disorder			
Blood/Lymph Disorder			
Cancer			
Cardiovascular Disorder			
Diabetes			
Ear, Nose, Throat Disorder			
Endocrine/Metabolic Disorder			
GI Disorder			
GU/Renal Disorder			
Musculoskeletal Disorder			
Neurologic Disorder			
Psychiatric Disorder			
Respiratory Disorder			
Skin Disorder			
Other Medical History			

Parent/Guardian Signature: ______________________

Printed Name: ______________________ Date: ______________________

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Entirely Kids Pediatrics Office Policies

Thank you for choosing Entirely Kids Pediatrics for your child's medical care. Our goal is to provide quality care to parents and patients, so we strive to make your visit as pleasant and stress-free as possible. We ask that you please review the information below regarding our office policies in order to avoid any misunderstandings in the future.

Office Hours

Our office is open Monday through Friday, 08:30am - 12:00pm and 1:00pm - 5:00pm; we are closed for lunch from 12:00pm to 1:00pm. Should we miss your call during normal business hours, please leave us a message, and we will return your call promptly.

After Hours

For any emergencies, please visit your nearby emergency room. We recommend Children's Medical Center in Plano. If you have an urgent matter that you need to discuss with the physician after-hours, please call our office main line and select the option to leave a message with the on-call physician. The doctor will return your call as soon as possible.

Appointments

- **Scheduling** – When calling to schedule an appointment, our front desk will typically ask you the reason for the visit (i.e. for well-exam or illness). Please note that a well-exam cannot be done on the same day as an appointment scheduled for a sick visit or illness.
- **Late policy** – Please understand that late arriving patients can have an impact on the schedule of the physician and other patients. We kindly ask that if you are running late or won't be able to make your appointment, to notify us as soon as possible. If you are more than 15 minutes late to an appointment, we will try to work you in depending on the schedule for the day, but you may be asked to reschedule to a later date.
- **Cancellation/No Show** – We value your time and we ask that you do the same for us. For any cancellations, please give at least 24 hours notice. We make attempts to send appointment reminders 1-2 days before the appointment, but it is still your responsibility to maintain the appointment that your schedule. Excessive no-shows or short-notice cancellations may result in dismissal from the practice.
- As previously stated, we know your time is valuable, so we strive to stay on time and attempt to be as efficient as possible while still providing quality care. However, please understand that emergencies do occur, and we ask that you be considerate if we happen to run a little behind schedule.

Immunizations

At Entirely Kids Pediatrics, we firmly believe in the protective benefits of immunizations. While we would love to accommodate all families, we simply cannot put at risk the children who are too young to be immunized and any immunocompromised individuals. Therefore, we are unable to provide services to patients who decide not to be vaccinated. We follow the recommendations made by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices with respect to the childhood and adolescent immunization schedules. Should you have any questions or concerns regarding immunizations, we would be glad to address these at your child's visit.

Financial
As a courtesy to our patients, Entirely Kids Pediatrics is happy to file insurance claims on your behalf. If you also have a secondary insurance please let our staff know. We will need a copy of all cards. It is your responsibility to call your insurance company before your first appointment and make sure our office is In-Network with your insurance.
It is also your responsibility to inform our office of any changes in insurance coverage. Failure to do so will cause delays or denial of insurance payment.

Co-payments are due at the time of service. You will be billed for any deductible or co-insurance amounts, and/or fees for services not covered by your insurance (as stated in your insurance contract). If we are unable to verify insurance coverage prior to scheduled appointments, patients will be responsible for fees associated with office visits at the time of service.

Treatment of Minors
A parent or legal guardian must accompany a minor to their first appointment at this practice. For future visits, individuals who have been specifically listed on the patient's intake form as having permission to bring the child in may do so as requested by the parent or legal guardian. Please note that a photo ID is required in these circumstances. It is also the responsibility of the trusted individual to relay details of the visit back to the parent/legal guardian. Alternatively, the parent/legal guardian may refer to the patient portal for the visit summary.

Patient Portal
One of our goals is to make patient care and coordination more efficient for the family and for our office staff. We highly encourage families to utilize the patient portal to access medical records and submit non-urgent office requests. For access to the patient portal or for more information, please access
https://entirelykids.patientmedrecords.com

By signing below, I acknowledge that I have received, read and understand the above office policies for Entirely Kids Pediatrics.

Patient Name: ______________________________

Parent/Legal Guardian Name: ______________________________

Parent/Legal Guardian Signature: ______________________________ Date: __________

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Authorization to Consent to Treatment of Minor

I, ________________________, am the parent/legal guardian of ________________________, a minor child, and have the power to consent to medical treatment for him/her. In the event that I cannot be contacted or am not present for consent, I will authorize and appoint another individual to consent on my behalf; this authorization will be submitted in writing. Medical treatment in this office may include, but is not limited to, examination, immunizations, medication administration, imaging studies, procedures, and coordination of care with other specialties and providers.

I will indemnify and hold harmless from any expense or claim of any nature any entity that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.

________________________________ ________________________
Signature of Parent/Legal Guardian Date

____
Printed Name of Parent/Legal Guardian

Child's name: ____________________________
Birth date: ______________________________

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Disclosure of Protected Health Information

I understand that as part of my healthcare, Entirely Kids Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Entirely Kids Pediatrics' **Notice of Privacy Practices** provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the **Notice of Privacy Practices** and understand that I have the right to review the notice prior to signing this consent. I understand that Entirely Kids Pediatrics reserves the right to change the **Notice of Privacy Practices**, and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and Entirely Kids Pediatrics is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Entirely Kids Pediatrics has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

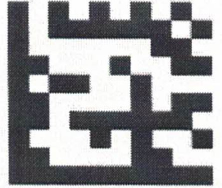
I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed Entirely Kids Pediatrics' **Notice of Privacy Practices** dated 01/01/2018.

______________________________	______________________________
Patient's Name (Print)	Date
______________________________	______________________________
Parent/Guardian (Print)	Signature of Parent/Guardian

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form



(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

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

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, 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. 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.

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"). 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;
- 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 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, ImmTrac2 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.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

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 on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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

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.**