LOUETTA PEDIATRICS, PLLC
PATIENT INFORMATION
(Please Print Clearly)

Patient Name: _____ DOB: _____ Sex: M F
LAST NAME, FIRST NAME (MM/DD/YYYY)

SS#: _____ Main Phone: _____ Dad's Phone #: _____ Mom's Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Father's Name _____ DOB: _____ SS#: _____

Occupation: _____ Employer: _____ Address: _____

Work #: _____ E-mail Address: _____

Mother's Name: _____ DOB: _____ SS#: _____

Occupation: _____ Employer: _____ Address: _____

Work #: _____ E-mail Address: _____

If you are not the parent, please complete this section:

Name of Legal Guardian: _____ DOB: _____ SS# _____

Address: _____ City: _____ State: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Occupation: _____ Employer: _____ Address: _____

Emergency Contact (other than parent)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Cell Phone #: _____

Pharmacy

Pharmacy: _____ Phone#: _____ Address/Location: _____

Insurance Information

Primary Insurance	**Secondary Insurance**
Insurance Company: _____	Insurance Company: _____
ID#: _____ Group# _____	ID#: _____ Group# _____
Address: _____	Address: _____
Phone#: _____ Eff. Date: _____	Phone#: _____ Eff. Date: _____
Policy Holder: _____	Policy Holder: _____
DOB: _____ SS#: _____	DOB: _____ SS#: _____
Relationship to Patient: _____	Relationship to Patient: _____

Please Initial

_____ I give permission for my child's picture to be used in the electronic chart

Please initial one:

_____ I **DO** authorize Louetta Pediatrics to leave my child's lab/work-up/Imaging results on my home/cell phone if I can't be reached.

_____ I **DO NOT** authorize Louetta Pediatrics to leave my child's lab/work-up/Imaging results on my home or cell phone.

Please sign below signifying that you authorize Louetta Pediatrics, PLLC to treat the above patient and that you authorize the release of correspondence and/or medical records to other medical providers involved in the child's care. By signing you are authorizing payment of medical benefits, understand and acknowledge that you are responsible for all charges NOT paid by the health insurance or third party payer. Your signature is also an acknowledgement that you have reviewed the clinic policy and the notice of privacy practices.

_____ _____
Signature of Parent or Guardian Date

Revised 5/2020

LOUETTA PEDIATRICS, PLLC
PATIENT HEALTH HISTORY

Child's Name: _____ Date: _____
DOB: _____ CurrentMedications:_____
Allergies (medication, food, insects):_____
_____

A. PREGNANCY & BIRTH:

1. Mother's age at birth _____
2. Did the mother have any illnesses during the pregnancy? Y / N
   List: _____
   _____
3. Any use of medications (other than vitamins & iron) or substances like drugs, marijuana, alcohol, vape or cigarettes Y / N
   List: _____
4. What was the baby Full term or Preterm? Y / N
   Weeks or Months of Pregnancy_____
   ☐ Vaginal birth ☐ Forceps ☐ C-Section-reason?_____
5. What was the birth weight? _____
6. Did your baby pass the Newborn Hearing Screen? Y / N
7. Did the baby have issues while in the hospital: Breathing, jaundice, heart problems, infections, feeding, urinating, stooling, etc Y / N
   List: _____

B. PAST MEDICAL HISTORY:

1. Date of last check up _____
2. Date of last dental check up _____
3. Any allergic reactions to medications, food, or insect bites?
   _____
4. Any reactions to immunizations? Y / N
   Which ones? _____
5. Any hospitalizations other than for birth? Y / N
6. Any serious injuries/surgeries/illness? Y / N
   Explain _____
7. Over the counter medications taken regularly? Y / N
   _____

C. FAMILY HISTORY

1. Are the child's parents both in good health? Y / N
2. Circle any diseases that the child's parents, grandparents, brothers, aunts, uncles have had (Indicate affected person): anemia, asthma, allergies, diabetes, high blood pressure, SIDS high cholesterol/triglyceride, tuberculosis, mental illness, COVID obesity, AIDS/HIV, Bleeding/Bruising, blood transfusion, sickle cell, hemoglobinopathy, sudden death while exercising or while sleeping, irregular heart beat, pacemaker use, thyroid disorder, Cancer of _____ other genetic disorders_____
   _____
3. List age, sex, and general health of siblings:_____
   _____
   _____

D. FEEDING & NUTRITION

1. Does your child have appetite issues? Y / N
2. Was there severe colic, spitting up or any unusual feeding problem during the first 3 months? Y / N
3. Any food intolerance/idiosyncrasy? Y / N
4. Was the child breastfed, bottle fed (formula) or both? _____
   How many months was breast milk given?_____
5. If still on formula, list what kind & how a many oz in 24 hrs
   _____
6. Is your child on whole milk, 1% or 2% milk: _____
   How many times does your child drink milk in a day?
   _____

E. REVIEW OF THE SYSTEMS:

1. Has your child had frequent ear infections? Y / N
2. Any eye problems? Y / N
3. Has he/she had any problems with her teeth? Y / N
4. Does he/she get frequent sore throat/ strep? Y / N
5. Is there any pneumonia, recurrent cough asthma, allergies? Y / N
6. Does he/she have a heart murmur or any heart problems? Y / N
7. Any problems with urination? Y / N
8. Any problems with diarrhea or constipation? Y / N
9. Have there been any seizures or other problems with the nervous system? Y / N
10. Any eczema, hives, or any other skin conditions? Y / N
11. Has your child even been anemic? Y / N
12. Any history of bleeding or frequent bruising? Y / N
13. Was there muscle/ bone disorder or fracture? Y / N
    Fractured body part: _____
    _____
14. Please list any other medical problems:
    _____
    _____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit up without support? _____
2. At what age did he/she learn how to walk? _____
3. Was able to say any words at 1 1/2 yrs of age? Y / N
4. How does your child compare to others his/her age?
   _____
5. Does he/she have any trouble sleeping? Y / N
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? Y / N
8. Does he/she get along with other children? Y / N
9. Circle if your child has had any of the following: Nail biting, thumb sucking, bed wetting, bad temper, problems with toilet training, hyperactivity inattention, nightmares, speech problems, problems with discipline, others
   _____
   _____
   _____
10. Has there been use of cigarettes/vape, marijuana, alcohol, drugs?
    _____

G. ENVIRONMENT

1. Circle what applies: private house, apartment, mobile home, pets (_____), carpeting, peeling paint, mold, roaches, rats, insects
2. Do you know the hottest water temp in your house? Y / N
3. Is there a working smoke alarm on each floor of the house? Y / N
4. Does your child always use a car seat/ seat belt when in the car? Y/ N
5. Is there anybody in the house who smokes (including use of vape), uses drugs, marijuana or has alcohol problems? Y / N
6. Does your child wear a helmet when riding bike? Y / N
7. Does your child attend daycare and/ or school? Y / N
8. History of travel outside of USA _____ Date_____

H. IMMUNIZATION

Up to date Y / N
Do you have the record? Y / N

I. LAST PEDIATRICIAN/ADDRESS/PHONE

_____

LOUETTA PEDIATRICS, PLLC

CONSENT TO TREAT A CHILD IF NOT BROUGHT IN BY A PARENT

AUTORIZACION PARA SERIVICIOS MEDICOS

PATIENT'S NAME _____ DOB _____ DATE _____
NOMBRE DE PACIENTE *FECHE DE NACIMIENTO* *FECHA*

I, _____, _____ (relationship to the child) give my permission as the parent/legal guardian of the above named child to the following persons;

Yo, _____, _____ *(relación al paciente) autorizo como padre/guardián de el niño/a a las siguientes personas;*

Name (*Nombre*)	Relationship to Child (*Relaccion Paciente*)

SIBLING INFO *(INFORMACIÓN DE HERMANOS)*

Please write the name and date of birth of any siblings that also attend the clinic;
Por favor escriba el nombre y feche de nacimiento de los hermanos que asisten a la clínica;

Name (*Nombre)*	DOB *(Feche de Nacimiento*)

Parent/Guardian Signature
Firma del Padre o Guardián

Date
Fecha

Tel # for Verification
Telefono

LOUETTA PEDIATRICS, PLLC OFFICE POLICY

LATE POLICY

Please arrive 15-30 minutes before your appointment for insurance verification and paperwork. If you are more than 15 minutes late to your appointment, we may have to move your child's appointment later in the day when schedule allows. You also have the option to reschedule.

CANCELLATIONS

If unable to make your child's appointment, please call to cancel within 24 hours of your scheduled time.

NO SHOW

If your child has 3 accumulative "NO SHOWS" we reserve the right to dismiss the patient from our practice. In the event that this happens, you will receive a dismissal letter from our office giving you a 30-day period to find another healthcare provider.

WALK-IN POLICY

Walk-in appointments are accepted when schedule allows and depending on the severity of illness. In all cases the child will be assessed by a nurse/MD and may be referred to the Emergency Room.

ANSWERING SERVICES

If it is a medical emergency, please call 911 or go directly to the nearest Emergency Room. For non-emergency matters please call during regular business hours. If your child has ***an URGENT PROBLEM THAT CANNOT WAIT FOR THE REGULAR BUSINESS HOURS, call the office and you will be transferred to the doctor.*** We appreciate it if you call for only *urgent* matters.

WELL EXAMS

Please be sure to make your appointment as necessary. Appointments are scheduled yearly for children 3yrs and above. Below 3yrs well exams will be after hospital discharge, 2wks, 2m, 4m, 9m, 12m, 15m, 18m, 24m, & 30m.

IMMUNIZATIONS

Louetta Pediatrics firmly believes in disease prevention and avoidance of infection spread by immunization. We encourage parents/guardians to read about vaccines from aap.org, cdc.gov, or dshs.texas.gov. Immunization exemption must be filled/submitted to the TX Dept of Health if parents/guardians opt out of immunization for their child/children.

SPORTS CLEARANCE

Ability to participate sports depends on the child's health and family health history. Clearance will be on hold pending evaluation/treatment and/or referral to a specialist if there are issues.

PRESCRIPTIONS

Prescribing any medication requires a visit to the doctor. Once the number of refills run out, contact the clinic if the patient still suffers from the condition needing medication. Louetta Pediatrics does not respond to pharmacy requests for refills. Medications given by a previous pediatrician will not be refilled immediately pending review of the medical records and also applies to ADHD/ADD medications. For ADHD/ADD medication refills, the patient will need to be seen by the Dr. every 4-6 weeks. Other psychotropics are not refilled or given.

FORMS/PREAUTHORIZATON

Bring forms that need to be filled out by the physician to the clinic. It may take 1-14 business days to be completed.

MEDICAL RECORDS REQUEST

A medical release form needs to be filled out before releasing any medical record. Copying your records (including shot records) require a fee according to the guidelines by the TX Medical Board.

INSURANCE/PAYMENT/COPAYS/DEDUCTIBLES/PROOF OF INSURANCE

You must submit a copy of your current valid insurance. You are responsible for understanding the patient's insurance benefits. If the insurance is not able to pay for the service, you are financially responsible for the services rendered. Pay by cash, check, or credit card for any balance due upon receiving the statement. There is a $35 Return Check Fee. All co-pays & deductibles must be paid at the time of service. Patients with an outstanding balance must make arrangements for payment prior to being seen by the provider. Accounts over 90 days past due will be considered delinquent and will be referred to a collection agency.

CUSTODY AND MEDICAL CARE AGREEMENT

Above documents must be provided at the time of the first visit. Any disagreements between families regarding the care of the child or children should be settled between the parents. The parent who authorizes treatment or brings the child to be seen is responsible for payment. If a divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other.

TESTING AND REFERRALS

You are responsible for completing your child's lab work/ tests, and following up with specialists as recommended by the physician. If your child is enrolled in a managed care insurance plan, your child must be seen by our office before seeing a specialist. No retroactive referrals will be given. We require at least one week's notice to arrange your referral for the specialist.

TELEMEDICINE

Telemedicine is offered by appointment through phone or video but there are conditions or diseases that cannot be diagnosed without confirmatory exams, tests, and/or lab work. Your child/children may be asked to visit the clinic if needed. If telemedicine is not a covered benefit of the health insurance or the patient is not eligible, the parent/guardian must agree to pay the self-pay amount of the service.

VIDEO/AUDIO RECORDINGS/CELLPHONE USE

Video recording, audio recording, and cell phone use are **strictly prohibited** while inside the office.

NOTIFY THE CLINIC FOR ANY CHANGES IN YOUR INSURANCE, TELEPHONE NUMBER, OR ADRRESS.

We sincerely appreciate you choosing Louetta Pediatrics for your child's care. Please sign below to acknowledge that you understand our clinic's policy and agree to comply.

Patient's Name: _____ DOB:_____

_____ _____

Signature of Parent or Guardian Date

LOUETTA PEDIATRICS, PLLC

Notice of Privacy

Uses and Disclosures of Treatment Payment and Healthcare Operations (TPO)

1) Treatment: Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, we will send the results of your laboratory tests and procedures to all health care professionals for treatment or consultation.
2) Payment: Your health information may be used to seek payment from your health plan and from other sources of coverage. A bill may be sent to you or a third party payer. The information accompanying the bill may include information that identifies you as well as your diagnosis, procedures and supplies used.
3) Law enforcement: Your health information may be disclosed to law enforcement agencies without your permission. We will support government audits, inspections and law enforcements.
4) Public Health: Your health information may be disclosed to public health agencies as required by the law. For example, certain communicable diseases to the state's public health department.
5) Health care operations: The medical staff may use information to assess the care and outcomes of your case. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Non-TPO Information

Disclosure of your health information or its use for any purpose other than those listed above will require your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization.

Additional uses of Information

1) Appointment Reminders: Your information will be used by our staff to send you appointment reminders.
2) Information about treatments: Your health information may be used to send you information on the treatment and management of your condition.

Individual Rights

You have certain rights under federal privacy standards. These include the:

- Right to request restriction on the use and disclosure of your protected information
- Right to receive confidential communications concerning you medical condition and treatment
- Right to inspect and copy your protected health information
- Right to receive an accounting of how and to whom your protected information has been disclosed
- Right to receive a printed copy of this notice

As permitted by law, the practice reserves the right to modify privacy practices as outlined. These changes may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit.

I have reviewed this form and give permission to the Louetta Pediatrics, PLLC to use or disclose my health information in accordance with the guidelines of HIPAA regulation. I acknowledge receipt of this notice and received a signed copy. If I decline not to acknowledge receipt of this notice, the practice will not treat me.

I authorized payment of my medical benefits to the practice for the services rendered to me.

_____ _____ _____

Patient's Name DOB Parent/Guardian Printed Name Signature Date

Louetta Pediatrics, PLLC
Telemedicine Consent Form

I am the parent/guardian of patient above. I agree to participate in a telemedicine evaluation. I understand that I can withdraw my permission anytime. I understand that if I do not choose to participate in a telemedicine session I will pursue face to face consult.

I give consent for the patient who may be defined as my child or a child who I have legal responsibility, to receive care and treatment at Louetta Pediatrics, PLLC through Telemedicine Services. I authorize the electronic transmission of the patient's medical information (including medical records, photos, notes) for evaluation, diagnosis, treatment and billing. I am aware that the same confidentiality information security practices apply.

I understand that a telemedicine service requires an appointment and that telemedicine services hours follow the regular clinic hours. I understand I would have to call the clinic (281-826-0016) for urgent medical questions or needs. Louetta Pediatrics' staff do not monitor this site for urgent questions or concerns.

I understand that telemedicine services have limitations and that the patient may have to come in for a face to face examination, for lab work or other diagnostic tests. I acknowledge that the Louetta Pediatrics' provider cannot be held liable for advice, recommendations and/or decisions based on factors not within their control: inability to visualize well or listen to body parts, distortions of images that may result from electronic transmission, or incomplete/inaccurate data provided by patients/parents/guardians and etc.

I understand that in choosing to participate in telemedicine, some parts of the exam may involve physical tests conducted by the individuals at my/my child's location at the direction of the telemedicine healthcare provider.

I understand that telemedicine services may be limited or unavailable as a result of technological or equipment failures. I understand that it may be necessary for others to be present during the visit other than my child's healthcare team and provider in order to operate the video equipment. These individuals are bound to maintain confidentiality of all information obtained. I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that either the Louetta Pediatrics provider or I can discontinue my/my child's telemedicine visit if it is felt that the video connection is not adequate for the situation.

I understand that each child/patient requires a separate telemedicine call and appointment. The Louetta Pediatrics healthcare provider cannot address the next patient's concerns until after the first appointment ends and a new a new call starts. I understand that by doing this, each call's notes and pictures are filed under the patient's medical record.

I understand that if the telemedicine is not a covered benefit of the health insurance or if my child is not eligible for it, I as a parent/guardian agree to pay the self-pay amount of the service. I also understand that co-pays or deductible that insurances do not cover must be paid prior to the telemedicine service. I agree to make the payment for this service over the phone credit card prior to each telemedicine session.

Patient's Name: _____ DOB: _____

Contact info for Telemedicine Services:

Cell # _____ Alt Cell # _____

Email: _____

_____ _____

Parent/Guardian Signature Date

Revised 07/2020

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

Texas Vaccines for Children (TVFC) 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: ____/____/____
   MM DD YYYY
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.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	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

Medicaid:

Medicaid Number: _____

Date of Eligibility: _____

CHIP:

CHIP Number: _____

Group Number: _____

Date of Eligibility: _____

Private Insurance:

Name of Insurer: _____

Insurer Contact Number: _____

Insurance Name: _____

Policy or Subscriber Number: _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac2)
MINOR CONSENT FORM

(Please print clearly)

ImmTrac 2
Texas Immunization Registry

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

____ / ____ / _____ ****Children under 18 years only.***
Child's Date of Birth

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 (under 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.state.tx.us** 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

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

***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.