URGENT CARE

PEDIATRIC HEALTH HISTORY

Date: _____ Check-in Time _____

Child's Name: _____Date of Birth _____ ☐ Male ☐ Female

Preferred Language: _____

***Responsible party for minor:** Last, first name and middle initial *this person would be responsible and receive the bills after insurance responded			Date of Birth
Social Security Number	Marital Status	Sex	Home Telephone # Ok to leave a message? ☐ YES ☐ NO
Mailing Address			Relationship to Guarantor

Email Address: _____

Insurance Company: _____Same as last visit? ☐ YES ☐ NO

Today's Symptoms: _____

Drug Allergies**:** _____Pharmacy/City: _____

IF CHILD WAS A PATIENT WITHIN THE <u>LAST YEAR,</u> PLEASE INDICATE ANY CHANGES BELOW:

PREVIOUS PATIENTS: NO CHANGES ☐ **(no need to complete the form)**

<u>Child's Health History: Check any of the following the child has ever been treated for:</u>

___Anemia/ Blood problems	___Asthma	___Diabetes
___Frequent ear infections	___Tubes in ears	___Hearing Loss
___Head Injury	___Frequent headaches	___Frequent throat infections
___Seizures	___ADD/ADHD	___Sickle Cell anemia
___Cancer /where_____	___Stomach/Bowel problems	___Thyroid problems
___Kidney/Bladder problems	___Vision/eye problems	___Lung problems
___Anxiety	___Depression	___Seasonal allergies

List Others: _____

List Surgeries: _____

_____

Current Medications: _____

Does anyone in the household smoke? ☐ YES ☐ NO Other personal household habits? _____

Are all immunizations up to date? ☐ YES ☐ NO

Parent/Guardian Signature: _____

URGENT CARE

PEDIATRIC HEALTH HISTORY

RELEASE OF INFORMATION-PLEASE LIST ALL PERSONS AUTHORIZED TO OBTAIN MEDICAL/FINANCIAL INFO

Last, first name and middle initial	Relationship:
Last, first name and middle initial	Relationship:
Last, first name and middle initial	Relationship:
Last, first name and middle initial	Relationship:

EMERGENCY CONTACT / EN CASO DE EMERGENCIA

Emergency Contact	Emergency Contact's Telephone #

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY

The patient agrees to general medical treatment by TexomaCare providers and understands and consents to the review and use of his/her medical records by any TexomaCare provider. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

I understand that this facility will bill my insurance as a standard office visit and will not be applied towards Urgent Care benefits.

➔**Signature of patient / legal representative:**

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and/or spouse/children may be used and disclosed and how you can get access to this information. I acknowledge that the TexomaCare Notice of Privacy Practices has been provided.

➔**Signature of patient / legal representative**:

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

The authorization form is to give consent to someone(s) other than a parent/legal guardian for the medical treatment of the patient for any unhealthy condition or well visits.

➔**Signature of Parent , Patient or Head of Household**	**Date**