Bootin and Savrick
Pediatric Associates, P.A.

BIOLOGICAL FAMILY HISTORY

DOES ANY FAMILY MEMBER HAVE:	YES	NO	DON'T KNOW	RELATIONSHIP TO CHILD
CHILDHOOD HEARING LOSS				
NASAL ALLERGIES				
ASTHMA				
TUBERCULOSIS				
HEART DISEASE (BEFORE AGE 55 YRS OLD)				
HIGH CHOLESTEROL/TAKES CHOLESTEROL MEDICATION				
ANEMIA				
BLEEDING DISORDER				
DENTAL DECAY				
CANCER (BEFORE AGE 55 YRS OLD)				
LIVER DISEASE				
KIDNEY DISEASE				
DIABETES (BEFORE AGE 55 YRS OLD)				
BED-WETTING (AFTER 10 YRS OLD)				
OBESITY				
EPILEPSY OR CONVULSIONS				
ALCOHOL ABUSE				
DRUG ABUSE				
MENTAL ILLNESS/DEPRESSION				
DEVELOPMENTAL DISABILITY				
IMMUNE PROBLEMS, HIV OR AIDS				
TOBACCO USE				
ADDITIONAL FAMILY HISTORY				

PAST HISTORY

HAS YOUR CHILD EVER HAD:	YES	NO	DON'T KNOW	HAS YOUR CHILD EVER HAD:	YES	NO	DON'T KNOW
CHICKENPOX				SLEEP PROBLEMS; SNORING			
FREQUENT EAR INFECTIONS				CHRONIC OR RECURRENT SKIN PROBLEMS			
PROBLEMS WITH EARS OR HEARING				FREQUENT HEADACHES			
NASAL ALLERGIES				CONVULSIONS OR OTHER NEUROLOGIC PROBLEMS			
PROBLEM W/ EYES OR VISION				OBESITY			
ASTHMA, BRONCHITIS, BROCHIOLITIS, OR PNEUMONIA				HISTORY OR SERIOUS INJURIES/FRACTURES/CONCUSSIONS			
ANY HEART PROBLEM OR HEART MURMUR				USE OF ALCOHOL OR DRUGS			
ANEMIA OR BLEEDING PROBLEM				TOBACCO USE			
BLOOD TRANSFUSION				ADHD/ANXIETY/MOOD PROBLEMS/DEPRESSION			
FREQUENT ABDOMINAL PAIN				DEVELOPMENTAL DELAY			
CONSTIPATION REQUIRING DOCTOR VISITS				DENTAL DECAY			
RECURRENT URINARY TRACT INFECTIONS AND PROBLEMS				HISTORY OF FAMILY VIOLENCE			
KIDNEY DISEASE OR UROLOGIC MALFORMATIONS				HAS YOUR CHILD EVER TESTED POSITIVE FOR TB SKIN TEST			
BED-WETTING (AFTER 5 YRS OLD)							

PROBLEMS WITH PERIODS: **YES** **NO** AGE OF FIRST PERIOD: _____

ANY OTHER SIGNIFICANT PROBLEM/SURGERY:

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS:

_____

_____

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PATIENT HISTORY

HOUSEHOLD

PLEASE FILL OUT THE FOLLOWING TABLE ACCORDING TO THE HOUSEHOLD MEMBERS ONLY

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS

ARE THERE ANY SIBLINGS NOT LISTED ABOVE? **YES** **NO**

IF YOU ANSWERED YES, PLEASE LIST THEIR NAME, AGE, AND WHERE THEY LIVE

WHAT IS THE PATIENT'S LIVING SITUATION IF NOT WITH BOTH BIOLOGICAL PARENTS?

IF ONE OR BOTH PARENTS ARE NOT LIVING IN THE HOME, HOW OFTEN DOES THE CHILD SEE THE PARENT(S) NOT IN THE HOME?

BIRTH HISTORY

BIRTH WEIGHT _____
WAS THE PATIENT BORN AT TERM? **YES** **NO**
WAS DELIVERY: **VAGINAL** **CESAREAN**
IF CESAREAN, WHY?

WERE THERE ANY PRENATAL OR NEONATAL COMPLICATIONS? **YES** **NO**
IF YES, EXPLAIN:

WAS A NICU STAY REQUIRED? **YES** **NO**
IF YES, EXPLAIN:

INITIAL FEEDING: **BREAST MILK** **FORMULA**
IF BREAST MILK, HOW LONG DID YOU BREAST FEED?

DURING THE PREGNANCY, THE MOTHER USED:

TOBACCO **YES** **NO**
ALCOHOL **YES** **NO**
MEDICATIONS **YES** **NO**
IF USED MEDICATIONS, PLEASE LIST THEM:

DRUG USE? **YES** **NO**
IF YES, WHAT? _____ WHEN? _____

GENERAL

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? **YES** **NO** **DON'T KNOW**
IF NO, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITIONS? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD HAD ANY SURGERY? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN:

IS YOUR CHILD ALLERGIC TO MEDICINE OR DRUGS? **YES** **NO** **DON'T KNOW**
IF YES, PLEASE EXPLAIN:

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PATIENT REGISTRATION FORM

PATIENT'S LEGAL NAME: _____
(LAST) (FIRST) (MIDDLE)

PATIENT'S BIRTHDAY: _____ SEX: _____ HOME PHONE #: _____

DAY TIME #: _____ CELL PHONE #: _____ PAGER #: _____

PATIENT'S ADDRESS: _____ CITY/STATE: _____ ZIP: _____

WITH WHOM DOES THE CHILD LIVE: _____ LEGAL GUARDIAN: _____

FATHER'S NAME: _____ MOTHER'S NAME: _____

FATHER'S ADDRESS: _____ MOTHER'S ADDRESS: _____

_____ _____

FATHER'S EMPLOYER AND PHONE #:

EMPLOYER: _____

OCCUPATION: _____

SOCIAL SECURITY #: _____

BIRTHDAY: _____

TX. DRIVER'S LICENSE #: _____

MARITAL STATUS: S M D W SEPARATED

EMERGENCY CONTACT: NAME _____ PHONE: _____ RELATION: _____

MOTHER'S EMPLOYER AND PHONE #:

EMPLOYER: _____

OCCUPATION: _____

SOCIAL SECURITY #: _____

BIRTHDAY: _____

TX. DRIVER'S LICENSE #: _____

EMAIL: _____

NAME OF INSURANCE COMPANY: _____ PHONE #: _____

POLICY HOLDER: _____ POLICY/GROUP #'S _____ / _____

NAME AND ADRESS OF LAST DOCTOR WHO SAW THIS PATIENT: _____

_____ PHONE # _____

DATE OF LAST VISIT: _____ WHY WAS CHILD SEEN: _____

WHO REFERRED YOU TO OUR OFFICE: _____

LIST NAME OF SIBLINGS CURRENTLY PATIENTS HERE: _____

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION IS COMPLETE AND CORRECT. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE HEALTH CARE PROVIDER AND UNDERSTAND THAT I AM REPSONSIBLE FOR ANY UNPAID BALANCE.

WE WILL TRY TO COLLECT FROM YOUR INSURANCE CARRIER FOR 90 DAYS. IF THE INSURANCE HAS NOT BEEN PAID AFTER 90 DAYS IT WILL BECOME YOUR RESPONSIBILITY. WE WILL THEN BILL YOU FOR 60 DAYS, AFTER 60 DAYS IF A BALANCE REMAINS, WE WILL START COLLECTION PROCEDURES.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

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INSURANCE
BILLING POLICY

Most of our patients are now on insurance programs that require us to bill their insurance. We are happy to do this for you. The contracts that we have with your insurance all guarantee that they will pay your child's claim in less then 90 days and many of them are required to pay even more quickly. Therefore, we will be happy to bill your insurance company for both office and hospital charges. After 90 days, the balance will become your responsibility. If your insurance company pays after that time, we will promptly credit your account and refund your money.

We have a group of full time employees working on your insurance claim. However, delayed or unpaid claims payment may be due to multiple problems that are beyond our control. Therefore, if your claim is not paid within 30-45 days, it would help if you called the insurance company yourself to check on the claim and any reasons for the delay. Sometimes the insurance company is simply waiting for additional information from you before they pay the claim. It is also helpful if you can get the name of the person that you spoke with, so that our office can communicate with the same person. We personally check with the insurance company regarding your specific insurance benefits and that is what we use to process your account. If you disagree with these benefits,
please call your insurance company to discuss it and get a contact person's name and number for us to use. Also, if your insurance company coverage changed, please inform us immediately so that we may file your claim with the correct company. If you can help us in these ways, it will avoid making the entire balance your responsibility.

By signing below, I acknowledge that I have been informed that after 90 days any bills left unpaid by my insurance company, after contractual adjustments have been made, will be my responsibility.

_____

Child's name

_____

Parent/Guardian Signature Date

7501 Fannin, Suite 850
Houston, TX 77054

p. 713-795-9500
fax 713-795-9590

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

(Please Check One)

☐ I,_____, have received a copy of Bootin & Savrick's
Patient / Guardian

Notice of Privacy Practices.

☐ I,_____, refuse to accept a copy of Bootin & Savrick's
Patient / Guardian

Notice of Privacy Practices.

_____ _____
Signature of Patient / Guardian Date

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____

I understand that as part of my healthcare, this organization 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 serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

O **I request the following restrictions to the use or disclosure of my health information:**

_____

_____

_____

PATIENT:

X _____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

OFFICE USE ONLY:

O Accepted
O Denied

_____ _____ _____

Signature | Title | Date