

TODAY'S DATE: ___/___/___

Patient's Last Name: _____ Patient's First Name: _____ D.O.B. ___/___/___			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Sibling's Name(s): _____ DOB ___/___/___, _____ DOB ___/___/___, _____ DOB ___/___/___			
RACE <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Africa American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other <input type="checkbox"/> Refused to disclose.			
ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused to disclose			
Mailing Address		City	State
Zip			
Email for Patient Portal: _____@_____		Insured's Employer: _____	
1)Parent's Name: _____ D.O.B: ___/___/___ Cell Phone: _____-_____-_____			
Email: _____@_____ Social Security Number: _____-_____-_____			
2)Parent's Name: _____ D.O.B: ___/___/___ Cell Phone: _____-_____-_____			
Email: _____@_____ Social Security Number: _____-_____-_____			

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Company Name		Insurance Company Name	
Address		Address	
Phone #:		Phone #:	
Identification Number	Group Number	Identification Number	Group Number
Responsible Party Name	Date of Birth	Responsible Party Name	Date of Birth
Patient's relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Responsible Party Social Security _____-_____-_____	Patient's relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Responsible Party Social Security _____-_____-_____
Preferred Pharmacy: _____		Preferred Pharmacy Location: _____	

EMERGENCY CONTACT AND AUTHORIZATION FOR NON-PARENT/GUARDIAN TO
 ACCOMPANY PATIENT, SPEAK TO DOCTOR/STAFF, GIVE AUTHORIZATION TO TREAT, MEDICATE, VACCINATE, AND MAKE GENERAL HEALTH DECISIONS REQUESTED
 BY TH DOCTOR. THE PERSONS LISTED BELOW WILL NEED TO PRESENT A PHOTO IDENTIFICATION AT TIME OF SERVICE

Name	Relationship to patient	Cell Phone
Name	Relationship to patient	Cell Phone
Name	Relationship to patient	Cell Phone

Bloom Pediatrics Consent Form

Assignment and Release of Financial and Medical Records

I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release all information contained in my financial and medical records to my insurance company, health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered. I permit a copy of this authorization to be used in place of the original.

 Patient or Authorized Person's Signature

_____/_____/_____
 Date

PATIENT'S NAME: _____ TODAY'S DATE: ___/___/_____

Financial Obligation

I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and I fully understand that I am fully responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities and ultimately responsible for payment in full if my insurance company does not pay in a timely manner.

Divorce/Custody/Adoption Case Policy

The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance. To provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the front desk. If parent or guardian exclusions are stated in any court order, you must provide the order for documentation for the patient's safety. A court order is required for the patient's chart for all adoptions and guardian assignments outside of the biological parents.

Annual Wellness/Physical Policy

- All patients are required to have an annual well exam regardless of the need for vaccines. Any patient that fails to have annual physical TWO consecutive years will be considered NOT COMPLIANT and might not be able to schedule any appointment with this practice.
- If a patient has any symptoms or treatment other than wellness, the annual check-up could be rescheduled for a later date and the copay (if applicable) will be applied.

Vaccination Policy

The providers at this facility follow the required and recommended vaccines according to the schedule published by the centers for disease control (CDC) and the American Academy of Pediatrics (AAP). I acknowledge and consent to the above policy unless otherwise indicated.

No Show Policy

Patients must give us advance notice if they need to reschedule their appointments. A "No Show" of \$25 could be applied to missed appointments that are not canceled 24 hours in advance. If any family member exceeds more than 3" No Shows", the family may be subjected to dismissal from the practice effective 30 days past the last no show appointment.

Consent For Treatment

I hereby authorize the providers, nurses, medical assistants, and staff to conduct examinations, administer treatment and medications as they deem necessary and advisable. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care procedures consistent with Dr. Ramona Ataya-Dakour Notice of Privacy Practices. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Authorization for Release of Information

1. Can we leave results to internal and external office testing or referrals in voicemail? Yes No

Advanced Practice Nurse Consent for Treatment

This facility has on staff an advanced practice nurse to assist in the delivery of medical care. An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs. I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

PATIENT'S NAME: _____ TODAY'S DATE: ____/____/_____

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Permission for Telehealth Visits

Telehealth is a way to visit with health care providers, such as your doctor or nurse practitioner.

- You can talk to your provider from any place, including your home.
- Your provider may decide you still need an office visit.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the internet for telehealth, use a network that is private and secure.
- There is a small chance that someone could use technology to hear or see your telehealth visit.
- You can stop using telehealth anytime, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- A telehealth visit will cost the same as an office visit.

If you decide you do not want to use telehealth again, please call 409-832-1225. By signing this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.

I have read each of the statements above and authorize, understand, and agree to each statement.

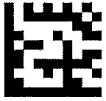
Patient or Authorized Person's Signature

____/____/_____
Date

Patient's Information			Child's Medical History		Mother			
Patient's Name:							Prenatal care provider:	
D.O.B:							Trimester prenatal care began: —1 —2 —3	
Place of Birth:							Number of living children —	
Birth Weight: lb oz							Mother's age at birth —	
Birth Length: Inches							Vitamins	— YES — NO
Biological Adopted Stepchild Guardian							Iron	— YES — NO
Hours of labor:			New Born Hearing Test (in hospital)		Number of years between previous pregnancy and this child:			
Delivery: _____ weeks			___ Normal	___ Abnormal				
1. Newborn Blood Screening		Date: _____	Hepatitis	— YES — NO				
2. Newborn Blood Screening		Date: _____	Immunization Current	— YES — NO				
Nursery			Dental Care Current	— YES — NO				
Type of delivery:			Trauma/Injury	— YES — NO				
Vaginal Caesarean			Hospitalization	— YES — NO				
Age at Discharge: _____ days			Medications	— YES — NO	Vaginal bleeding	— YES — NO		
Complications: Breech Multiple birth Other			Anemia	— YES — NO	Anemia/Blood disorder	— YES — NO		
BIRTH			Early Childhood Caries	— YES — NO	Hypertension	— YES — NO		
Difficulty with Initial breathing		— YES — NO	Ear Infections	— YES — NO	RH Negative	— YES — NO		
Heart Murmur		— YES — NO	Bladder/Kidney Inf.	— YES — NO	Diabetes	— YES — NO		
Infection		— YES — NO	Strep Throat	— YES — NO	Premature labor	— YES — NO		
Transfusion		— YES — NO	Pneumonia	— YES — NO	Injury/Surgery	— YES — NO		
Seizures		— YES — NO	Developmental Delay	— YES — NO	Flu like illness	— YES — NO		
Jaundice req. treatment		— YES — NO	Vision/Hearing Problem	— YES — NO	Alcohol	— YES — NO		
Referral Made		— YES — NO	Seizures	— YES — NO	Street Drugs	— YES — NO		
Muscle/Bone disease		— YES — NO	Toxin/Lead Exposure	— YES — NO	Kidney Problems	— YES — NO		
Childhood Hearing Impairment		— YES — NO	Allergies	— YES — NO	STDs	— YES — NO		
Inherited/Genetic Diseases		— YES — NO	Asthma	— YES — NO	Hepatitis (A, B, C)	— YES — NO		
Major birth defects		— YES — NO	Eczema	— YES — NO	Exposure to TB	— YES — NO		
Tuberculosis		— YES — NO	Substance Abuse	— YES — NO	Dental Disease	— YES — NO		
Psychiatric Disorders		— YES — NO	Alcohol	— YES — NO	OTC Meds	— YES — NO		
Physical/emotional/sexual abuse		— YES — NO	Drugs	— YES — NO	Prescription MEDs	— YES — NO		
Domestic violence		— YES — NO	Tobacco	— YES — NO	Tobacco	— YES — NO		
Other		— YES — NO	Other	— YES — NO	Caffeine	— YES — NO		



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, Maiden Name, Race (select all that apply), Ethnicity (select only one)

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records.

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 and I further understand that DSHS will include this information in the Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder.
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. 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)

Provider Statement
PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. DO NOT fax to the Texas Immunization Registry. Retain this form in your client's record.

Contact Information
Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Release of Medical Records

Bloom Pediatrics

Ramona Ataya-Dakour MD, FAAP
Rebecca Balfanz, APRN, CPNP
3070 College Street Suite 205 Beaumont, Texas 77701
Tel: 409-832-1225 Fax: 855-638-6067

Previous Pediatrician/Provider Information:

Doctor/Provider Name: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Parent/Guardian Information:

I, _____, authorize the release of my child/children medical records

named below:

Patient Information:

Name: _____ D.O.B.: ____/____/____

Name: _____ D.O.B.: ____/____/____

Name: _____ D.O.B.: ____/____/____

Name: _____ D.O.B.: ____/____/____

Specific information to be disclosed

<input type="radio"/> Entire Medical Record
<input type="radio"/> Immunization Record
<input type="radio"/> Labs/Imaging
<input type="radio"/> Consult Notes

The undersigned understands and acknowledges that:

- He/she has the right to end the authorization by submission of a written request to the doctor or medical group listed above. Uses and disclosures (releases) made between the authorization date and the date of ending or expiration date are permitted and approved by the undersigned.
- The doctor or medical group listed above is prohibited from conditioning treatment, payment, or enrollment upon giving authorization.
- The information released may be subject to re-disclosure (release) by the recipient and may no longer be protected by privacy law.

Signature of Patient or Guardian

Date:

Notice to the individual giving this authorization

This authorization shall operate as a complete release of liability of Dr. Ramona Ataya-Dakour's Office, its officers, agents and employees for the release of information as specified above. We have no control over the recipient's use of the information. The person who we disclose your information may disclose it to someone else and this office will no longer be able to protect the information.