REGISTRATION FORM Clinica De Niño's, 6445 High Star. Houston, TX 77074, Tel: 713-777-1117

Section I: Patient Information **Date**_____

Name: _____Date of birth_____

Address:_____City:_____State:_____Zip_____

Phone (_____) _____ _____ Cell Phone (_____) _____

Mother's Name_____ Date of birth : _____

Employer_____ Work Phone_____

Father's name_____ Date of birth_____

Person to contact in case of emergency_____ Relationship:_____ Phone_____

Section II Guardianship

With your authorization below, please provide up to three (3) person's name that may accompany your child who you hereby gives authorization for diagnosis and treatment of your child .We will need a note each time parents are not presence.

1._____ _____Relationship to Patient: _____
2._____ Relationship to Patient: _____
3._____ Relationship to Patient: _____

Parent Signature_____ Date:_____ Phone (____)_____
Relation: Parent/Legal Guardian/Other_____

Section III Consent to treat and assignment of benefits

I. Consent to Treat:

1. I voluntarily consent to the medical care, treatments and diagnostic tests that doctors and associates, assistants, or her other health care providers believe are necessary for my child.
2. I understand that by signing this form, I am authorizing my doctor, her associates, assistants or health care providers to treat my child until I withdraw my consent.
3. I understand that My Doctor, her associates have made no warranties, guarantees or promises to me about treatment for my child or about any results or cures from my treatment.
4. If my child has any advance directive (directive to Physician, Power of Attorney for healthcare, our of Hospital DNR),

II. Assignment of Benefits

1. I understand that I am responsible for paying all the fees charged by my doctor or her associates for providing care to my child which are not covered services under my insurance. I understand this means that I am responsible for paying deductibles, co-pays, co-insurance and any other charges for non-covered services at the time of each service.
2. I authorize my insurance company to pay CLINICA DE NINOS, P.A. directly for the fees I am charges and that my insurance covers.

By signing below, I acknowledge that I have the opportunity to ask questions about this form and I was also given a copy of the HIPAA Notice of Privacy Practices

Signature Parent/Guardian:_____ Date_____ Relation:_____
Signature of Witness: _____ Date: _____ ___

Clinica De Ninos ,P.A.

Patient History

Today's Date: _____

Name_____ _____

Date of Birth: _____

Mothers Name: _____

Fathers Name: _____

Who referred you to us?

_____

A .Pregnancy and Birth:

1. Did you have any illness during pregnancy? No Yes
2. Did the baby come on time? Yes No
3. What's his/her birth weight? _____
4. Was the baby born vaginally? Yes No
5. Did the baby have any problem while in the hospital? No Yes
6. Which hospital was the baby born? _____

Who is your OB (Prenatal) doctor or clinic? _____

B. Family History:

1. Circle the disease if any family members:
(Parents, Grandparents , Uncles, Aunts, Brothers, Sisters):
Tuberculosis, Diabetes, Asthma, Allergy, Seizures, Cancer, Mental Illness, Inherited Disease, Kidney Disease, HIV, Blood Disorder

2. List ages, sex, and general health of brothers and sisters:

Names	Age	Sex	Healthy
_____			Yes No
_____			Yes No
_____			Yes No
_____			Yes No

3. Have any of your children died? No Yes

4. Circle if he/she ever had any Infections or Illnesses

Many times ear infections, Urination Problems, Convulsion, Speech Problems, Learning Problems, Hearing Problems, Bed Wetting, Eye Problems, Constipation, Poor Appetite, Diarrhea, School problems, Problems with Potty Trained Measles, Pneumonia, Serious Accident, and Broken Bones

Operations: _____

Hospitalizations: _____

5. At what age him/she walked alone? _____

6. Did he/she say a few words at 18 months? Yes No

C .Health Maintenance: Give the Date:

1 .When was his/hers last anemia and lead blood test?

Date: _____

Was the result normal? Yes No

2. When was his/hers last eye exam?

Date: _____

Was the result normal? Yes No

3. When was his/hers last hearing test?

Date: _____

Was the result normal? Yes No

4. When was his/hers last tuberculosis Skin Test?

Date: _____

Was the result normal? Yes No

5. When was his/hers last dental visit?

Date: _____

6. Has he/she had all vaccinations for age? Yes No

D .Allergies: Circle If:

Eczema, hives, wheezing, asthma, allergies to medication, and Foods

E.Others :

Do you have any Hospital papers or vaccine records with you?

Yes No

If you have any papers/records please present them to front desk!

TB Questionnaire

Name: _____ Date: _____

This questionnaire is about tuberculosis. Tuberculosis can be transmitted to children by adults who live or spend a great deal of time with them. Tuberculosis is transmitted by a person with tuberculosis to another person through airborne droplets that are coughed or sneezed into the air and breathed in by the child. This transmission of infection is more likely to occur when the child and the infectious person spend a lot of time together in a closed environment, like a small room, a car, or other similar situations.

Adults who have tuberculosis will often have the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills, and night sweats.

- Children with tuberculosis frequently do not have symptoms.
- A person can have tuberculosis infections and not have active tuberculosis.
- Not everyone who coughs has tuberculosis.
- Tuberculosis is preventable and treatable.
- Children can become very ill with tuberculosis.
- We need your help to find out if your child has been exposed to tuberculosis.

	YES	NO	I DON'T KNOW
Has anyone in your family had tuberculosis?			
Has your child or any of your other children or family member ever had a positive TB skin test?			
Has your child been around anyone with tuberculosis since his/her last skin test?			
Was your child born in a foreign country where there is a lot of TB, or has your child ever visited relatives there?			
Has your child been around any adult who coughs a lot (relative, baby sitter, teacher, and neighbor)?			
Has your child had any health problems over the past year such as a bought of two or more weeds duration?			
Has your child had contact with anyone who is/has been:			
a drug user?			
HIV infected?			
in jail/prison?			
Foreign-born?			

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

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

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

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, 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 ImmTrac. 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 ("ImmTrac"). Once in ImmTrac, 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 ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac 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)

Questions? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/27/11

TEXAS Department of State Health Services

***PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.*

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar eligibility screening record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: ____/____/____ Age: _____
mm/dd/yy

Parent/Guardian/Individual of Record:

_____
Last Name First Name MI

Provider's/Clinic's Name:
Clinica de Ninos P. A.

Please check the first category that applies; check only one.

- ☐ (a) Is enrolled in Medicaid, or
- ☐ (b) Does not have health insurance (uninsured), or
- ☐ (c) Is an American Indian, or
- ☐ (d) Is an Alaskan Native, or
- ☐ (e) Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or
- ☐ (f) Is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Fully, privately insured children are no longer eligible for TVFC vaccine.

- ☐ (g) Has private insurance that covers vaccines (not TVFC eligible).

Signature: _____ Date: _____

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)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

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