FAIRWAY PEDIATRICS
4100 Fairway Dr. Ste. 300
Carrollton, TX 75010
Tel: (972) 492-8880
Fax: (972) 492-8818

PATIENT REGISTRATION FORM

(Please print)

Today's date:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:
Birth date:	SSN:	Sex: ❑ Male ❑ Female
Street address:		
City:	State:	ZIP Code:
Primary contact:	Primary contact no.:	
Secondary contact:	Secondary contact no.:	

PRIMARY CONTACT INFORMATION

Name:	Birth date:
Preferred contact method for scheduling/reminder calls (Check all that apply): ❑Voice message ❑ Text message ❑ Email	Email address:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:

The above information is true to the best of my knowledge.

_____ _____

Patient/Guardian signature *Date*

FAIRWAY PEDIATRICS
4100 Fairway Dr. Ste. 300
Carrollton, TX 75010
Tel: (972) 492-8880
Fax: (972) 492-8818

NAME:	**DOB:**

BIRTH HISTORY *(FOR NEWBORNS ONLY)*	
Hospital of birth:	Number of weeks pregnant:
Type of delivery: ❑ Vaginal ❑Forceps ❑ Cesarean	
Problems or Complications around birth? ❑Yes ❑ No *If yes, please explain:*	
Birth weight:	Feeding: ❑ Breast ❑ Bottle ❑ Both
Problems at birth? ❑Yes ❑ No *If yes, please explain:*	

CHILD HISTORY	
Are immunizations up to date? ❑ Yes ❑No ❑ Don't know	Allergies? ❑ Yes ❑ No *If yes, what kind?*
Has your child been hospitalized? ❑Yes ❑ No *If yes, when and what for?*	
Has the child ever had surgery? ❑ Yes ❑No *If yes, what kind?*	
Is the child on any medications? ❑ Yes ❑No *If yes, please list all medications:*	

FAMILY HISTORY	
Mother's name:	Father's name:
Mother's Date of Birth:	Father's Date of Birth:
Health problems of parents:	Health problems of siblings:

List below any of the baby's immediate relatives (mother, father, sibling, grandparent, aunt, uncle, and cousin) who have had any of the following illnesses:

Condition	Yes	No	Family member
Allergies			
Anemia			
Arthritis			
Asthma, Emphysema, TB			
Birth Defects			
Blood Disease			
Cancer (specify)			
Cystic Fibrosis			
Diabetes (Adult/Juvenile)			
Drug/Alcohol use			
Eye/Ear Disorder			
Heart Disease			
High Blood Pressure			
Infections (frequent or severe)			
Learning problems			
Kidney/Liver Disease			
Mental illness/Retardation			
Metabolic/Genetic Disease			
Nerve Disorder (Epilepsy, C.P)			
Rheumatic Fever			
Sickle Cell Trait/Disease			
Thyroid Disease			
Other			

FAIRWAY PEDIATRICS
4100 Fairway Dr. Ste. 300
Carrollton, TX 75010
Tel: (972) 492-8880
Fax: (972) 492-8818

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY

_____ *(initial)* The patient agrees to general medical treatment by Fairway Pediatrics and understands and consents to the review and use of his/her medical records by Fairway Pediatrics. 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, including remainder of deductibles, 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

_____ *(initial)* I hereby authorize Fairway Pediatrics 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 Fairway Pediatrics. 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.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

_____ *(initial)* I hereby acknowledge that I have been presented with a copy of Fairway Pediatrics Notice of Privacy Practices.

The Following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Fairway Pediatrics to share my protected health information with:

Name	**Relationship**	**Name**	**Relationship**
Name	**Relationship**	**Name**	**Relationship**

Name: _____

Relationship to child: _____

Signature: _____**DATE**_____

Fairway Pediatrics
Dr. Jian Wang

Financial Policies

- **Insurance:** We accept most of insurance plans. If you are not insured by a plan we have contracted with, payment in full is expected at each visit. If you are insured by a plan we have contracted with, but their system states your coverage is termed for any reason, payment in full for each visit it required until we can verify your coverage. Once coverage can be confirmed, claims will be resubmitted and upon receipt of payment, a refund will be issued.

- **Co-payment/Co-insurance:** Co-payment and co-insurance MUST be paid at the time of service. Since this is part of contract with your insurance company, failure to collect payment can be considered fraud.

- **Deductible:** If you have not met your deductible, you are responsible to pay in full at the time of visit.

- **Non-covered services:** Some services you receive may be uncovered by your insurance carrier. You are obligated to pay the "PATIENT RESPONSIBILITY" portion for these services.

- **Benefits:** Please be aware our billing department is not responsible to know what your specific plan will or will not cover. Thus, knowing your benefits is ultimately patient's responsibility.

- **Newborns:** It is your responsibility to insure your newborn is promptly added to insurance. If your newborn does not have medical insurance on the date of service, you are responsible for the full balance to be paid at the time of service and no refund will be granted.

- **No Show Fee**: We reserve right to charge you no show or cancellation fee. Each patient will be charged $25 for each no show.

Please sign below to indicate your understanding and agreement with our financial policies.

_____ _____

Signature Date

_____

Print Name

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

ImmTrac Texas Immunization Registry

(Please print clearly)

Last Name | *For Clinic/Office Use*

First Name | **Middle Name**

Gender: ☐ **Male** ☐ **Female**

Date of Birth

Address | **Apartment #** | **Telephone**

City | **State** | **Zip Code** | **County**

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 immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac. *For a family member younger than 18 years of age, a parent, legal guardian or managing conservator may grant consent for participation for that minor by completing the ImmTrac Minor Consent Form (# C-7). The ImmTrac Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of my 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, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____
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 ImmTrac 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 • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EF11-13366
Revised 05/18/12

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.