Helotes
pediatrics

Information Form

Welcome to Helotes Pediatrics! We appreciate the opportunity to work with you and your child. The following information is provided so that we may serve you better:

VACCINATIONS. Helotes Pediatrics follows the immunization guidelines recommended by the American Academy of Pediatrics (AAP). We will not be able to see patients who do not follow these guidelines; so as to prevent diseases and health complications for our patients that do immunize.

PAYMENTS. All applicable fees, deductibles, coinsurance, or copays must be paid at the time of your appointment. We accept cash, checks, VISA, MASTERCARD, AMEX, and DISCOVER. There is a $25 charge for returned checks. Parents who present checks that are dishonored are required to pay future amounts due with cash, money orders or credit cards.

NEWBORNS. Most insurances no longer "auto add" newborns to parents' policies and will not pay for visits during the first 30 days unless the child has been added to the policy during that time. For unverified newborn visits during the first 30 days, a deposit of $80.00 will be charged ($25.00 for subsequent visits). We will promptly refund and credit balances after insurance has been verified and payment has been received.

INSURANCE. Prior to your child's first visit, we verify eligibility and benefits with your insurance carrier. Prior to succeeding visits, please notify us of any changes in your insurance. Please have insurance card at every visit.

CANCELLATIONS/NO SHOWS. If you need to cancel or reschedule your appointment, please call us at least 24 hours in advance of the scheduled time. Medicaid "no-shows" or last minute cancellations risk reassignment. Non-Medicaid clients will be charged for last minute cancellations or missed appointments. *Effective 01/01/2010, the fee is $20 for acute visits and effective 06/12/2017 there is a $40 fee for missed well visits.*

LATE ARRIVALS. Clients arriving more than ten minutes late will be worked in only if another patient seeing the same physician can be moved up. Otherwise, rescheduling may be necessary.

WALK-INS. Unfortunately, Helotes Pediatrics is no longer able to schedule patients on a "walk-in" basis.

TELEPHONE CONSULTATIONS. If you require a return call from your nurse or doctor, we will call you on the same day. Scheduling may dictate that routine calls be returned late in the day.

WAITING ROOM. Please do not bring food or drink into the clinic. (Of course, baby bottles are permitted.) Since we have no provision for child care, please do not leave children unattended in the waiting room.

EMERGENCY SERVICE. If your child has a life threatening emergency, call 911 or proceed to the nearest emergency facility. For minor emergencies and acute illness (i.e. fever, vomiting) after hours, Call-A-Nurse is available at 226-8773.

ANSWERING SERVICE. We operate a 24-hour answering service for consultation. Just call our main number at 372-0505.

YOUR ATTENDING PHYSICIAN. Once you have selected a Physician, that provider will be your Attending Physician throughout your child's treatment. If, during the course of your child's treatment, your Attending Physician is temporarily unavailable, the other provider may treat your child. Your child will return to the care of your Attending Physician upon her return.

MEDICATION REFILL REQUESTS. It is important to have your physician write your prescription at the time of your visit. You may request refills through your pharmacy. After business hours, we will only approve medication refill requests on an emergency basis. NOTE: ADHD medication refills requiring triplicate prescriptions should be initiated 2-3 days in advance. There is a $5 fee for triplicate prescription "re-writes" (prescriptions written again because the initial prescription was not picked up within the required time).

LAB TEST RESULTS. Because of telephone line limitations, we ask that you not call to check on lab results. We will call you to report results.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

Signature/Printed Name_____/ _____Date_____

Patient Name_____Witness Signature_____

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Patient Information

PATIENT INFORMATION					
Name (Last, First Middle)				Today's Date	
Date of Birth	Age	Gender Male / Female	Patient's SSN		
Home Address (Street/Apt)		City	State	Zip	
PRIMARY CARETAKER - CONTACT INFORMATION					
Name of Responsible Party			Relationship to Patient		
Home Address (Street/Apt)		City	State	Zip	
Home Phone	Cell Phone	E-Mail	Preferred Phone No		
Employer		Work Phone			
Employer Address		City	State	Zip	
PRIMARY INSURANCE					
Name of Insurance Company		Phone			
Address		City	State	Zip	
Name of Policy Holder			Relationship to Patient		
DOB of Policy Holder	SSN of Policy Holder	Group Number	Policy ID Number		
SECONDARY INSURANCE (if applicable)					
Name of Insurance Company		Phone			
Address		City	State	Zip	
Name of Policy Holder			Relationship to Patient		
DOB of Policy Holder	SSN of Policy Holder	Group Number	Policy ID Number		
IS ANY OTHER PERSON ALLOWED TO BRING THE ABOVE PATIENT IN FOR A MEDICAL VISIT?					
Name		Relationship to Patient			
Name		Relationship to Patient			
IN CASE OF EMERGENCY, CONTACT:					
Name		Relationship to Patient			
Home Phone	Cell Phone	Work Phone			

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Authorization Form

PATIENT INFORMATION	
Name (Last, First Middle)	Today's Date

PLEASE INITIAL THE FOLLOWING STATEMENTS	
	Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, Co-Pay and non-covered service amounts.
	I authorize the release of any medical information necessary to process the applicable claim.
	I authorize payment of medical and surgical benefits to Helotes Pediatrics, PA

Signature of Responsible Party	Date
Relationship to Patient	

Please let us know if you would like medical records transferred to our office
We would be happy to help you!

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY	
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will used and disclosed. I understand that I am entitled to receive a copy of this document.	
Signature of Parent/Guardian	Date
Name/Signature of Office Representative	Date

Confidential Health History

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Patient's Name:	Patient's Date of Birth:	Today's Date:

PAST MEDICAL HISTORY: Please check any current or past medical conditions (for patient) listed below

o ADD or ADHD	o Cerebral Palsy	o Hearing Loss	o Speech Delay
o Anaphylaxis (severe allergic reaction)	o Congenital Heart Defect	o Hydronephrosis	o Thyroid Problems
o Amblyopia	o Concussion	o Immune Deficiency	o Urinary Reflux (VUR)
o Asthma/Reactive Airway Disease	o Cystic Fibrosis	o Juvenile Rheumatoid Arthritis	o Urinary Tract Infection
o Asperger	o Developmental Delay	o Meningitis	Please list any others:
o Autism	o Diabetes Mellitus, Type I (Juvenile)	o Mental Retardation	_____
o Blood Disorder (Sickle cell, Hemophilia, Thalassemia)	o Down Syndrome	o Migraine Headaches	_____
o Celiac Disease	o Dyslexia	o Prematurity	_____
	o Eczema/Atopic Dermatitis	o Scoliosis	
	o GERD (Reflux)	o Seizure (Febrile or Non-Febrile)	

SURGICAL HISTORY: Please check any past surgeries (for patient) listed below

o Adenoidectomy	Date/Age:	o Eye Surgery	Date/Age:	o PET (ear tubes)	Date/Age:
o Appendectomy	Date/Age:	o Frenulectomy (tongue-tie)	Date/Age:	o Sinus Surgery	Date/Age:
o Bladder Repair	Date/Age:	o G-Tube (Feeding tube)	Date/Age:	o Tonsillectomy	Date/Age:
o Circumcision	Date/Age:	o Hernia Repiar	Date/Age:	o Tracheostomy	Date/Age:
o Congenital Heart Surgery	Date/Age:	o Mastoidectomy	Date/Age:	o VP shunt	Date/Age:
o Other:		o Other:		o Other:	

HOSPITALIZATIONS: Please list any hospitalizations (not including simple ER visits)

Date	Hospital	Reason for hospitalization

MEDICATIONS: Please list all medications and dosages

MEDICATION	Frequency of Dose	MEDICATION	Frequency of Dose

LATEX ALLERGY: Is the patient allergic to Latex? Yes / No	If yes, what type of reaction does the patient experience?

11085 Bandera Rd Ste. 102 San Antonio, TX 78250
(210) 372-0505

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MEDICATION ALLERGY: Please list any drug/medication allergies below			
Name of Medication	Type of Reaction	Name of Medication	Type of Reaction

FOOD ALLERGIES: Please list any severe food allergies			
Name of Food	Type of Reaction	Name of Food	Type of Reaction

FAMILY HISTORY: Please check any illnesses in close family members and indicate relationship to patient		
o Unavailable (Patient is adopted)	o Cardiomyopathy	o Schizophrenia
o ADD/ADHD	o Celiac Disease	o Scoliosis
o Anaphylaxis (Severe Allergic Reaction)	o Cystic Fibrosis	o Seizure (Febrile or Non-Febrile)
o Arrhythmia (Heart Rhythm Problems)	o Diabetes Mellitus, Type I (Juvenile)	o Sudden Infant Death
o Asthma	o Diabetes Mellitus, Type II (Adult onset)	OTHER:
o Asperger	o High Blood Pressure	
o Autism	o High Cholesterol	
o Bipolar Disorder	o Migraine Headaches	

SOCIAL HISTORY:		
Who does the patient live with?	Patient has:	Education:
(Please check below)	o Sister	o Public School
o Both Parents	o Sisters	o Private School
o Mother	o Step-Sister	o Home School
o Father	o Step-Sisters	o Special Education
o Aunt	o Brother	o Day Care
o Uncle	o Brothers	o Mother's Day Out
o Foster Parents	o Step-Brother	
o Maternal Grandmother	o Step-Brothers	Type of Pets at Home
o Maternal Grandfather	o Half-Sister	_____
o Paternal Grandmother	o Half-Sisters	_____
o Paternal Grandfather	o Half-Brother	_____
o Siblings	o Half-Sisters	_____

Preferred Pharmacy (ex. Walgreens on Braun/1604) : _____

Parent signature: _____

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