



FETAL CARE CENTER  
DALLAS

## PEDIATRIC HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M F

Reason for Cardiology evaluation today: \_\_\_\_\_

### **BIRTH HISTORY:**

Birth Weight: \_\_\_\_\_ pounds \_\_\_\_\_ oz. Gestational Age: \_\_\_\_\_ weeks

#### **Pregnancy**

- Uncomplicated  
 Complicated

#### **Labor/Delivery**

- Normal  
 Complicated by C-section

#### **Neonatal Course**

- Uncomplicated  
 Complicated

Explain: \_\_\_\_\_

### **PAST MEDICAL HISTORY:**

Medical Conditions (ex: Asthma, Diabetes, ADHD): \_\_\_\_\_

Prior hospitalizations?  No  Yes Explain: \_\_\_\_\_

Prior Surgeries?  No  Yes Explain: \_\_\_\_\_

Current Medications:  None  \_\_\_\_\_

Allergies to Medications:  No  Yes (If Yes, please list with reaction): \_\_\_\_\_

Immunizations:  Up to date  Not up to date \_\_\_\_\_

Developmental Concerns: \_\_\_\_\_

### **DIET & FEEDING HISTORY**

Regular Diet for Age (> 1 year old)

Tube Feeds Amount Per Feeding \_\_\_\_\_ ml \_\_\_\_\_ oz Feeds Every \_\_\_\_\_ hrs

#### **(One year of age and younger)**

**Formula:** Amount per feeding \_\_\_\_\_ oz Feeds every \_\_\_\_\_ hr

**Breastfed:** Feeds Every \_\_\_\_\_ hr Duration of feeds \_\_\_\_\_ min

Any difficulty Feeding?  Yes  No

#### **Check all that apply**

#### **Explain**

<input type="checkbox"/>	Tires with Feeding	
<input type="checkbox"/>	Tachypnea with Feeding	
<input type="checkbox"/>	Diaphoresis with Feeding	
<input type="checkbox"/>	Other	

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FAMILY HISTORY:**

	<b>Check all that apply</b>	<b>Relation to Patient</b>
<input type="checkbox"/>	Congenital Heart Disease	
<input type="checkbox"/>	Sudden Death	
<input type="checkbox"/>	Arrhythmia	
<input type="checkbox"/>	Cardiomyopathy-Dilated	
<input type="checkbox"/>	Cardiomyopathy-Hypertrophic	
<input type="checkbox"/>	Coronary Artery Disease	
<input type="checkbox"/>	Hypertension (High Blood Pressure)	
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Heart Attack before age 50	
<input type="checkbox"/>	Murmurs	
<input type="checkbox"/>	Marfan syndrome	
<input type="checkbox"/>	Ehler- Danlos	
<input type="checkbox"/>	Long QT syndrome	
<input type="checkbox"/>	Congenital deafness	
<input type="checkbox"/>	High Cholesterol	
<input type="checkbox"/>	Epilepsy or Seizure disorder	
<input type="checkbox"/>	Mental Retardation	
<input type="checkbox"/>	Learning or attention problems	

Patient adopted; no family history known

**SOCIAL HISTORY:**

**Patient lives with?** (Check all that apply)

Mother  Father  Sister(s)  Brother(s)  Grandparents  Other \_\_\_\_\_

**Smokers in household?**

Mother  Father  Sister(s)  Brother(s)  Grandparents.  Other \_\_\_\_\_

**Attends school or daycare?**  No  Yes Grade: \_\_\_\_\_

**Exercise:**  Regular (on own)  Regular (PE)  Sedentary  Restricted  Competitive

Explain: \_\_\_\_\_

**General**

	<b>Check all that apply</b>	<b>Amount &amp; Frequency</b>
<input type="checkbox"/>	Tobacco Use	
<input type="checkbox"/>	Alcohol Use	
<input type="checkbox"/>	Illicit Drug Use	
<input type="checkbox"/>	Supplements Use	

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**REVIEW OF SYSTEMS**

(Please check if the patient has a history of any of the following)

<u>General:</u>	<input type="checkbox"/> Weakness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever
	<input type="checkbox"/> Appetite change	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain
<u>HEENT:</u>	<input type="checkbox"/> Eye Drainage	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Trouble Seeing
	<input type="checkbox"/> Corrective Lenses	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Ear Pain
	<input type="checkbox"/> Hearing Issues	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Gum Bleeding
	<input type="checkbox"/> Teething	<input type="checkbox"/> Facial Swelling	<input type="checkbox"/> Snoring
<u>Cardiovascular:</u>	<input type="checkbox"/> Fast Heart Rate	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Murmur
	<input type="checkbox"/> Irreg. Heart rate	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Syncope (fainting)
<u>GI:</u>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Blood in Stool
<u>GU:</u>	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Blood in Urine	
<u>Musculoskeletal:</u>	<input type="checkbox"/> Joint Pain & Swelling	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Stiffness
	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Swelling- hands & feet
<u>Derm:</u>	<input type="checkbox"/> Rash	<input type="checkbox"/> Skin Sores	<input type="checkbox"/> Hair Loss
	<input type="checkbox"/> Nail Changes		
<u>Neurological:</u>	<input type="checkbox"/> Weakness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness
<u>Endo:</u>	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Unexplained weight gain	<input type="checkbox"/> Unexplained weight loss
<u>Chest/Pulmonary:</u>	<input type="checkbox"/> Cough	<input type="checkbox"/> Frequent Pneumonia	<input type="checkbox"/> Chest Tightness
<u>Hematology:</u>	<input type="checkbox"/> Anemia	<input type="checkbox"/> Easy bruising/bleeding	
<u>Endocrine:</u>	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Excessive thirst/hunger	<input type="checkbox"/> Temp intolerance

\_\_\_\_\_  
*Signature of individual completing form*

\_\_\_\_\_  
*Date*

Relation to Patient: (Please check)     Self    Parent    Guardian

**Medical Staff ONLY**

Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_, MD



## CONSENT TO TREAT

I hereby give my consent to Fetal Care Consultants, LLC and authorize to provide my medical treatment. I understand that Fetal Care Consultants, LLC will explain my condition, foreseeable risks, and methods of treatment before treatment is provided. I authorize Fetal Care Consultants, LLC to perform any additional or different treatment that is thought necessary if in an emergency situation, or a condition is discovered that was not known previously. I have carefully read and fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the necessary procedure with the care provider.

*Please check:*

I have received and reviewed an explanation of the above checked treatments and associated risks of treatment.

I understand that audio and video recording is prohibited in the office.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Legal Guardian Name (if applicable)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Legal Guardian Signature (if applicable)

\_\_\_\_\_  
Date



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DALLAS

## PEDIATRIC NEW PATIENT REGISTRATION INFORMATION

### **Patient Information**

**Last Name:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Initial:** \_\_\_\_  M  F

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Home/Cell): \_\_\_\_\_ Email: \_\_\_\_\_

Race/Ethnicity:  American Indian or Alaska Native  Asian  Black or African American  
 Hispanic or Latino  Native Hawaiian or Other Pacific Islander  White

### **Parent/Guardian Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Primary Physician/Pharmacy Information**

Pediatrician/Primary Care: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Physician (if different): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Pharmacy Name/Location: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **Insurance Information**

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F

Relationship to Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F

Relationship to Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### **Emergency Contact (if different than parent/guardian):**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_



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## PEDIATRIC NEW PATIENT REGISTRATION INFORMATION

**Please read the following and sign below**

**ASSIGNMENT OF BENEFITS, BILLING POLICY, AND RELEASE OF MEDICAL INFORMATION:**

I hereby authorize my insurance benefits to be paid directly to Fetal Care Consultants of Texas, LLC or any of its wholly owned subsidiaries. I understand that I am financially responsible for all payments not made by my insurance company, including (i) patient responsibility amounts such as co-pays and deductibles, (ii) non-covered services, (iii) payments not made because of failure to follow payers' administrative requirements (except as otherwise agreed), (iv) if plans benefits are exceeded, or otherwise. I am also responsible if my insurance company does not pay in accordance with the Texas Prompt Payment Regulations.

I authorize release of all protected health information to my insurance company to obtain payment for services.

**MEDICARE PATIENTS:**

I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for any Medicare claim. I assign payment of Medicare benefits to my billing provider.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## CONSENT TO COMMUNCIATE MEDICAL INFORMATION

### **Voicemail Communication**

Many times, during the course of your care our providers will want to provide information to you about laboratory results or other medical issues. Sometimes it is difficult to connect with patients by phone, which delays our ability to relay information. Some patients prefer that we leave messages on their voicemails as a way to eliminate delays. Please indicate your preference as to how we can communicate information to you during your care as a patient here:

Yes, you may leave a message on my:

Home #: \_\_\_\_\_  Cell #: \_\_\_\_\_

No, do not leave any medical information on my voicemail

### **Request for email Communication**

Some patients prefer to communicate with our clinical and administrative support staff by eMail. However, as email communications is not encrypted, there is no assurance of confidentiality of information when communicating in this way. Nevertheless, we will communicate with you via eMail if that is more convenient for you. To do so, please provide us with your email information below:

Yes, I authorize email communication

email Address \_\_\_\_\_

No, I do not authorize email communication

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Legal Guardian Signature



## COMMUNICATION WITH PATIENT

### **Designation for Release**

It is the physician responsibility to ensure that the physician-patient relationship remains confidential. The privacy statement of our practice is the basis for how we treat your protected health Information (PHI). HIPAA allows physicians to use professional judgment on disclosing certain PHI to family, friends or legal representative without authorization. This form is an aid to our physicians in making determination regarding disclosure of such information. We realize that there may be times when the patient may not want another person to be informed about your medical condition and medical needs. The physicians want you to, if you so desire, to name the person whom you wish the office staff speak about your medical condition.

- The designation is valid unless you cancel it in writing
- If you designate no one, we may not release information to any family or friend.

I agree to designate the following person(s) be allowed to speak with a physician, nurse or staff at Fetal Care Consultants, LLC should it be necessary on my behalf. I hereby give permission to release to my designee any information about my medical condition or medical needs or status of my account and I release Fetal Care Consultants, LLC, its physicians and staff, from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Designated Person: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**I decline to designate another person to speak with my physician or staff.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Legal Guardian Signature





## FINANCIAL AGREEMENT

We would like to welcome you to our office and are happy you have chosen us for your medical care. Our goal is to provide you with the best care available. In order to meet this goal, we need your assistance and understanding of our patient policies. Our financial policy is an essential part of assuring the resources needed to maintain this vital healthcare facility are met for our patients.

We are here to help answer any questions you may have regarding your insurance coverage and payments. However, your insurance is a contract between you and your employer and the insurance company. It is your responsibility to understand the provisions, limits, and requirements of your individual benefit plan. We will file your claims directly to your company if we participate in your insurance. If we do not participate in your insurance, we will supply you an extra copy of your superbill to submit to your insurance company. We will also file secondary insurance if you have coverage. Any uncovered portion of your visit will be your personal financial responsibility. This includes any and all co-pays, co-insurance, deductibles and uncovered services. After your insurance has processed and insurance pays their portion of the bill, any remaining balance is your responsibility and due in full upon receipt. Furthermore, if "clean claims" submitted to an insurance carrier are not paid within the 30 day limit established by the Texas Prompt Payment Regulations, FCC reserves the right to bill you directly for our services.

Full payment is due at the time services are rendered. We accept cash, check, Master and Visa credit cards. Your copayment, deductible and coinsurance will be collected at the time of your visit, in addition to any previous balance on account. If you need an estimate of costs prior to your visit, please call our office and we will do our best to provide a rough estimate however this estimate is only a rough guidance. At the time of your visit the physician may deem additional services necessary depending upon your healthcare needs.

Patients will be billed for amounts due and have a financial responsibility to pay these amounts. If prompt payment is not received on any unpaid balances on your account after 3 statements, your account will be reported to a collection agency for delinquent status. Patients will be responsible for any collection, interest or legal expenses associated with the collection efforts.

If a patient presents an insufficient funded personal check (NSF check) for payment on their account they will be charged a \$35, as well as be required to pay for all future visits with cash, a money order, cashiers check or credit card.

Thank you for choosing us for your healthcare needs. We believe it is important our patients fully understand our financial policy and be well informed. It is your responsibility to notify us in writing of any changes in account status including phone, address, and insurance information. Our business office is open during office hours and we are more than happy to answer any questions you may have regarding our financial policy.

Please sign below to indicate that you have read this notice, understand the information it contains and that any questions you might have about the information presented herein have been answered to your satisfaction.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



FETAL CARE  
CENTER

## NO SHOW POLICY

When you make an appointment with us, we reserve a significant amount of time specifically for your consultation. Unfortunately, when a patient doesn't show up for their scheduled appointment, another patient loses an opportunity to be seen. For this reason, it is the policy of Fetal Care Consultants, LLC to call to reschedule or cancel a clinic appointment. Any patient that does not arrive for their scheduled appointment within a 15-minute window and does not call to cancel prior appointment is considered a no-show. Patients that do not follow this protocol will be assessed a \$25 no show fee.

The only exceptions to this requirement are a medical emergency, inpatient hospitalization or a crisis. For those patients utilizing Medicaid transportation, if your transportation is a no show, you must obtain a letter from Medicaid stating such in order to waive the no show fee for our office

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **For Children/Minors:**

Legal Guardian Name: \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_