

DR. SAROJINI BOSE, M.D.
ASHLEY PEDIATRICS DAY & NIGHT CLINIC

801 E NOLANA STE 13-A
MCALLEN, TX 78504
P (956) 686-2700
F (956) 686-2708

2029-A E GRIFFIN PKWY
MISSION, TX 78572
P (956) 424-3222
F (956) 424-3225

514 S CLOSNOR BLVD
EDINBURG, TX 78539
P (956) 287-2300
F (956) 287-2315

6201 S CAGE BLVD STE 5
PHARR, TX 78577
P (956) 283-7070
F (956) 283-7083

1001 S 10TH STE E
MCALLEN, TX 78501
P (956) 213-8400
F (956) 213-8333

PATIENT'S REGISTRATION FORM

Patient's Name: _____ DOB: _____ M _____ F _____

Patient's SSN: _____ Age: _____

Address: _____ City _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Number: _____ Alt Number: _____

Please List Siblings:

Name: _____ DOB: _____ M _____ F _____

Name: _____ DOB: _____ M _____ F _____

Name: _____ DOB: _____ M _____ F _____

Name: _____ DOB: _____ M _____ F _____

(*) Required Information

PARENT'S INFORMATION

* Father's Name _____ *DOB: _____ *SSN # _____

Employer: _____ Work Phone: _____ Ext # _____

* Mother's Name: _____ *DOB: _____ *SSN # _____

Employer: _____ Work Phone: _____ Ext # _____

PLEASE PRESENT YOUR INSURANCE INFORMATION AT THIS TIME

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Who referred you to our clinic or how did you hear of our clinic? _____

ASSIGNMENT OF BENEFITS

I hereby authorize Ashley Pediatrics to apply for benefits on my behalf for covered services rendered by the physician or the physician's order. I request that payment from my insurance company be made directly to Ashley Pediatrics.

Signature: _____ Relationship to patient: _____ Date: _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment. Unless other arrangements are made, I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child. I accept full financial responsibility for all charges not covered by my insurance. I have been provided with a copy of the Privacy Notice and have had an opportunity to object to the disclosures of my health insurance.

Signature: _____ Relationship to patient: _____ Date: _____

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INSURANCE

We will bill your insurance company as a courtesy to you; however payment of your medical bill is your responsibility and should be settled between you and your insurance company. It is your responsibility to know the coverage of your insurance policy. You are responsible for payment of services rendered that your insurance policy does not cover.

OUTSTANDING BALANCES

If we have not received payment from your insurance company and you have an outstanding balance of more than sixty (60) days from the date of service, you will be billed directly for payment. We will provide you with necessary information in order for you to be directly reimbursed by your insurance company. If no payment or payment arrangement is made for services rendered after ninety (90) days, your account will be passed to a collection agency and you will be responsible for your balance plus the cost of collection services. In the event of returned check(s) regardless of the cause there will be a charge of \$32.00 plus the fee of the check collection services. In the event that there is an overpayment, we will reimburse you within thirty (30) days following the end of the month in which the payment from your insurance company was received in order to clear our accounting system.

SECONDARY INSURANCE

If you have more than one insurance company, we will bill your primary and secondary insurance company. If your primary insurance denies payment, we will bill your secondary insurance. If no payment is received from your primary or secondary insurance, you will be responsible for any payment due.

MEDICAL RECORDS

In the event you need copies of your child's medical records or replacement of a lost immunization card, there is an administrative fee due at the time you request these services. You will also be required to bring an I. D. to show that you are one of the parents/legal guardians and to sign an authorization form. The copies will be available five (5) days after your request.

MINOR PATIENTS

All minor patients must be accompanied by a parent or legal guardian.

MISSED APPOINTMENTS

If you are unable to keep your appointment, please call to reschedule or to cancel your appointment twenty-four (24) hours prior to your schedule time.

**I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE FINANCIAL
RESPONSIBILITY STATEMENTS.**

Signature _____ Date _____

I hereby authorize direct payment of medical/surgical benefits to Ashley Pediatrics for services rendered. I understand that I am financially responsible for any medical or incidental information that may be necessary for either medical care or in processing for financial benefits.

Patient's Name _____ Date _____

Parent/Guardian Name _____ Date _____

Insurance/Medicaid #: _____

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NEWBORN QUESTIONNAIRE

Patient Name: _____
Mother's Name: _____

Date of Birth: _____
Mother's Age: _____

PREGNANCY: # Pregnancies _____ (Gravity) DELIVERY: Vaginal _____ Cesarean _____
 # of Births _____ (Parity) Anesthesia _____ Analgesia _____
 Blood Type _____ Forceps _____ Reasons _____
 Ultrasound _____ Amniocentesis _____

EXAMS

Hep B _____ Gonococo _____ Medications _____
 Hep C _____ Herpes _____ Alcohol _____
 AFP _____ Chlamydia _____ Smoking _____
 HIV _____ GBS _____ Other Recreational Drugs _____
 SYPHILIS _____ Other Diseases _____

COMPLICATIONS OF PREGNANCY

Urinary Tract Infection _____
 Hypertension _____
 Vaginal Bleeding _____
 Pre Term Labor _____
 Duration of Rupture
 Of the Membranes _____
 Maternal Fever _____
 Meconium Stained Amniotic Fluid _____
 Preclamsia _____
 Eclampsia _____
 Diabetes _____

CONDITION OF THE INFANT AT BIRTH

Diabetes _____ Weight _____
 Fetal Distress _____ Length _____
 Jaundice _____
 Fractures _____
 Hip _____
 Lungs _____
 Heart _____
 Cefalohematoma _____
 Caput _____
 APGAR _____
 Other Anomalies _____

OBSTETRICIAN NAME _____

PEDIATRICIAN NAME _____

HOSPITAL _____

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Patient's Name: _____

DOB: _____

BIRTH HISTORY

Type of Delivery _____ Term _____ Premature _____
 Months _____ Pregnancy Number _____ Other _____
 Birth Weight _____ Length _____
 Apgar Score _____ Circumcision _____ Blood Type _____
 Other _____

FAMILY HISTORY

MOTHER _____ AGE _____ OCUPATION _____
 FATHER _____ AGE _____ OCUPATION _____

SIBLINGS	AGE	SEX	HEALTH
1.			
2.			
3.			
4.			
5.			

DOES ANY FAMILY HAVE OR HAS HAD ANY OF THE FOLLOWING:

High Blood Pressure _____ Cancer _____ High Cholesterol _____
 Allergies _____ High Triglycerides _____

NUTRITIONAL HISTORY

Breast _____ Formula _____ Vitamin Supplement _____ Type _____
 Soft Food Added _____
 Appetite _____ Stools _____
 Allergies _____
 Other _____

DEVELOPMENTAL HISTORY

ACTIVITY	AGE	ACTIVITY	AGE
Held head up		Smiled	
Sat aided		Stood Aided	
Sat alone		Reached for objects	
First Teeth		Crawled	
Stood Alone		Walked	
Said Words		Sentences	

HABITS

Sleep _____ Naps _____ School _____ Bed Wetting _____ Plays _____

ILLNESS HISTORY

General _____ Allergies _____
 Varicella/Chicken Pox _____ Tonsillitis/Pharyngitis _____
 Ear Infections _____ Asthma/Bronchitis _____
 Serious Injuries _____ Operations _____
 Hospitalized _____ Other _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
 IMMUNIZATION REGISTRY (ImmTrac)
 NEWBORN REGISTRATION FORM



(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth **Newborns only.*

Child's Gender: Male Female

Mother's First Name

Mother's Maiden Name

Mother's Street 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 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 the 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.

Please mark the appropriate box to indicate your choice.

I **GRANT** consent for registration. I wish to **INCLUDE** my child's information in the Texas immunization registry.

I **DENY** consent for registration. I wish to **EXCLUDE** my child's information from 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

ImmTrac NB-2 Stock No. F11-11936

Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Revised 07/11/08



BIRTH REGISTRARS – Please enter newborn client information in Texas Electronic Registrar and **affirm** that consent has been granted. **DO NOT fax to DSHS. Retain this form in the client's birth record.**

Insurance/Medicaid #: _____

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|---|--|--|---|--|

Acknowledgement of Review of
NOTICE OF PRIVACY PRACTICES

I have reviewed this practice's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Reconocimiento De Haber Revisado El Aviso
ACERCA DE LAS PRACTICAS DE PRIVACIDAD

Yo he revisado el Aviso acerca de las Practicas de Privacidad, la cual explica como se puede utilizar la informacion de salud individual identificable. Yo comprendo que tengo el derecho de recibir una copia de este documento.

Firma del Paciente o Guardian Legal

Fecha

Nombre del Paciente o del Representa Personal

Descripcion de la Autoridad del Representa Personal