Dr. Robert S. Bloss

PATIENT INFORMATION

Patients Full Name_____(goes by_____)**Sex**____
(Nombre del Paciente) (Sexo)

Age _____ **Date of Birth** _____/_____/_____ **SS#** _____/_____/_____
(Edad) (Fecha De Nacimiento) (Numero De Seguro Social)

Mailing Address: _____ **Area Postal** _____
(Direccion) **City** (Cuidad)

Email Address: _____
(Dirección De Correo Electrónico)

Mother_____ **Home#** ( ) _____**Cell#** ( ) _____
(Madre) (# Tel de casa) (# tel de Cellular)

Address _____ **Area Postal** _____
(Direccion) **City** (Cuidad)

Employer_____ **Work#** ( ) _____
(Empleo) (# tel de Trabajo)

Father_____ **Home#** ( ) _____**Cell#** ( ) _____
(Padre) (# Tel de casa) (# tel de Cellular)

Address _____ **Area Postal** _____
(Direccion) **City** (Cuidad)

Employer_____ **Work#** ( ) _____
(Empleo) (# tel de Trabajo)

Emergency Contact _____**Relation** _____**Ph#.**_____
(Contacto de Emergencia) (Relacion) (# de tel)

Child's Pediatrician_____**Ph#.**_____
(Nombre del Pediatra) (Numero de Tel)

Race *(Raza)*:

❑ White ❑ Black or African American ❑ Hispanic ❑ American Indian or Alaskan Native ❑ Asian
❑ Native Hawaiian or other Pacific Islander ❑ Other Race ❑ Unreported/Refused to Report

Ethnicity/Cultural Background (Origen étnico/Fondo Cultural :

❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report

Language (Idioma):

❑ English; ❑ Spanish; ❑ Indian; ❑ Japanese; ❑ Chinese; ❑ Korean; ❑ French; ❑ German;
❑ Russian; ❑ Other _____

IF YOU ARE ON MEDICAID OR OTHER GOVERNMENT ASSISTANCE, WE MUST HAVE THE NAME OF THE DOCTOR WHO REFFERED YOU-SO THAT WE MAY FILE YOUR CLAIM.

INSURANCE INFORMATION

Medicaid#_____ **SS#**_____/_____/_____

Primary Insurance Co_____ **Ph#** ( ) _____
(Seguro Principal) (# de Tel)

Policy Holder_____ **DOB**_____/_____/_____
(Posesor de Poliza) (Feche de Nacimiento)

ID#_____ **Group#**_____ **SS#**_____
(# de Poliza) (# de Grupo) (# De Seguro Social)

Secondary Insurance Co_____**Ph#.**_____

Policy Holder_____ **DOB**_____/_____/_____
(Posesor de Poliza) (Feche de Nacimiento)

ID#_____ **Group#**_____ **SS#**_____
(# de Poliza) (# de Grupo) (# De Seguro Social)

Signature_____**Date**_____/_____/_____
(Firma) (Fecha)

Houston Pediatric Surgeons

(English/Spanish Attestation)

(If patient is over age 18, he/she must fill out paperwork)

Date/Fecha _____/_____/_____

Patient Name: _____, _____

Paciente **Last/Apellido** **First/Nombre**

Date of Birth/Fecha nacimiento _____/___/_____

Non-biological parent for patients under age 18 must have documents of guardianship

Padres no biologico de paciente menor de 18 tienen que tener documentos de tutela

Family History/Guardianship for treatment of minor/Historia familia/ Custodia o Tutela de paciente:

Patient presently lives with: (circle one) Mother/Father/Both/ Other:_____Relation

Paciente vive con: (trazar un circulo) Madre/Padre/los dos/otro:_____Relacion

Who is filling out this form?(Circle one) Biological parent/ foster/legal guardian/adult patient

Quien llena esta pagina?(circulo): Padre biologico/adoptivos/guardian/paciente mayor edad

I _____ attest the above information is accurate. Any falsification of the information above is subject to legal compliance.

Yo _____attesto la informacion es correcta. Falcificacion de esta informacion es subjeto a cumplimiento legal.

SIGNATURE/FIRMA:_____

Past Medical History:		**Historial Medica:**	
Has patient ever been diagnosed with: (Circle)		**Paciente sido diagnosticado: (tazar un circulo)**	
	What age		**Que edad**
Heart Disease		**Defecto de Corazon**	
Lung Disease		**Defecto de Pulmones**	
Bladder/Urine Infections		**Infecciones unrinarias**	
Neurological Impairments		**Defectos neurologicos**	
ADD/ADHD		**ADD/ADH**	
AIDS/HIV		**CIDA/VIH**	
BLEEDING DISORDER		**TRASTORNO SANGRANTE**	
PREMATURE-GESTATION PERIOD_____		**Prematuro-semanas de embaraso_____**	
Other Disease:		**Otra enfermedad:**	

ALLERGIES/ALERGIAS? YES/ NO/SI	**Surgeries/Cirugias ? YES /NO/ SI LIST ALL/HAGA LISTAR**	**Medication/medicamientos**

****It is your responsibility to alert us if any of the above information changes at every office visit****

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, HOUSTON PEDIATRIC SURGEONS, P.A. originates and maintain paper and/or electronic records describing any health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that HOUSTON PEDIATRIC SURGEONS, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that HOUSTON PEDIATRIC SURGEONS, P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code if Federal Regulations. Should HOUSTON PEDIATRIC SURGEONS, P.A. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
_____
_____
_____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

X_____ _____/_____/_____
Parent's Signature Date

HOUSTON PEDIATRIC SURGEONS
TRUTH IN LENDING STATEMENT

We file your claims as a courtesy and will be happy to assist you with any questions that you have concerning your claim. Please help us by making follow-up calls to your insurance company, for the status of your claim should your insurance company take longer than 45 days to send payment.

I authorize release of payment from my insurance carrier to be made to the above named party. I understand that if my insurance carrier had not paid my claim within 45 days the charges incurred are my responsibility.

I am fully aware that if my child does not become eligible for the TEXAS MEDICAID PROGRAM, I am fully responsible for all the charges applied from Houston Pediatric Surgeons. I am also aware that if my child becomes a Medicaid recipient, and I do not make Houston Pediatric Surgeons aware of the recipient number 15 days from the eligibility, I am also financially responsible for all the charges.

I FURTHUR UNDERSTAND THAT TREATMENT WILL NOT BE DENIED, AND IF SEEN WITHOUT A REFERRAL, THE CHARGE WILL BE MY RESPONSIBILITY.

Signature_____Date_____/_____/_____

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NOTICE CONCERNING COMPLAINTS

COMPLAINTS ABOUT PHYSICIANS, AS WELL AS OTHER LICENSEES AND REGISTRANTS OF THE TEXAS BOARD OF MEDICAL EXAMINERS, INCLUDING PHYSICIAN ASSISTANTS AND ACUPUNCTURISTS, MAY BE REPORTED FOR INVESTIGATIONS AT THE FOLLOWING ADDRESS.

TEXAS STATE BOARD OF MEDICAL EXAMINERS
ATTENTION: INVESTIGATIONS
1812 CENTRE CREEK DR. STE#.300
AUSTIN, TEXAS 78714-9134

ASSISTANCE IN FILING A COMPLAINT IS AVAILABLE BY CALLING THE FOLLOWING TELEPHONE NUMBER: 1-800-201-9353

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THE HARRIS COUNTY MEDICAL SOCIETY, THE PROFESSIONAL ASSOCIATION FROM LICENSED PHYSICIANS IN HOUSTON AND HARRIS COUNTY MEDIATES COMPLAINTS BETWEEN PATIENTS AND PHYSICIAN MEMBERS. FOR FURTHUR INFORMATION, PLEASE CONTACT THE HARRIS COUNTY MEDICAL SOCIETY AT THE FOLLOWING TELEPHONE NUMBER: 713-790-1838