pediatrix

UROLOGY OF CENTRAL TEXAS

# Follow-up Medical History

*Date* _____

*Patient Name:* _____

*Date of Birth:* _____

*Reason for today's visit:* _____

1. Since the last visit, has your child had any lab tests or x-rays for this problem? __Yes __No
2. If yes, which test, when and where were they performed? _____

_____

*New medical issues since last visit:*

_____

*Hospitalization(s) since last visit: Symptom and Date* _____

_____

*Surgeries since last visit: Procedure and Date* _____

_____

*Current Medications (please list):*

_____

*Allergies (medication, foods and environmental):* _____

*Pharmacy Name:* _____*Pharmacy Address:* _____

*PCP:* _____

*Specialists your child follows with:* _____

*Questions or concerns for today's visit:*

_____

_____

**AUSTIN**
1301 Barbara Jordan Blvd., Suite 302
Austin, TX 78723

**CEDAR PARK**
1301 Medical Pkwy, Suite 310
Cedar Park, TX 78613

**PHONE**: 512-472-6134
**FAX:** 512-472-2928
**childrensurology.com**

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# Patient Information

## Patient

Last Name: * _____ First Name: * _____ Nickname: _____

Date of Birth: * _____ Patient SSN: _____ Gender: * Male ____ Female ____ Non-binary ____

Race: American Indian or Alaskan Native ____ Asian ____ Black or African American ____ Native Hawaiian or other Pacific Islander ____ White ____

Other: _____ Decline: ____

Ethnicity: Hispanic/Latin ____ Not Hispanic/Latin ____ Other: _____ Decline: ____

Who referred you? (Please CHECK one) FAMILY ____ FRIEND ____ PHYSICIAN REFERRAL ____ WEBSITE ____

Person referring you: _____ Primary Care Doctor: * _____ Phone: * _____

**In case a parent is not able to accompany the child, please list names of individuals you are allowing to accompany and make possible medical decisions for the minor patient.**

**NAME: *** _____ **RELATIONSHIP: *** _____

**NAME:** _____ **RELATIONSHIP:** _____

### Parent 1

Last Name: * _____ First Name:* _____ DOB: * _____ Social Security #: * _____

Street Address:* _____ City: * _____ State: * ____ Zip: * _____

Cell Phone: * _____ Secondary Phone: * _____ Email: * _____

*Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

### Parent 2

Last Name: _____ First Name: _____ DOB: _____ Social Security #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Secondary Phone: _____ Email: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

## Emergency Contact

Last Name: * _____ First Name: * _____ Relation: * _____

Cell Phone: * _____ Secondary Phone: * _____

## Primary Insurance

***Policy Holder***

Last Name: * _____ First Name: * _____ Policy Holder's Birth Date: * _____

Insurance Provider: * _____ Insurance ID Number: * _____ Group Number: * _____

Provider Phone Number (from insurance card): * _____ Policy Holder's SSN: * _____ Relation to Patient: * _____

## Secondary Insurance

***Policy Holder***

Last Name: _____ First Name: _____ Policy Holder's Birth Date: _____

Insurance Provider: _____ Insurance ID Number: _____ Group Number: _____

Provider Phone Number (from insurance card): _____ Policy Holder's SSN: _____ Relation to Patient: _____

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER(S) - (Check <u>all</u> that apply)**

___**HOME TELEPHONE**
- ___OK to leave message with detailed information
- ___Leave message with call-back number only

___**WORK TELEPHONE**
- ___OK to leave message with detailed information
- ___Leave message with call-back number only

___**MOBILE TELEPHONE**
- ___OK to leave message with detailed information
- ___Leave message with call-back number only

___**WRITTEN COMMUNICATION**
- ___OK to mail to home address

___**PATIENT PORTAL**

**Email: *** _____

**PLEASE INITIAL**

*____ I acknowledge I have reviewed the HIPAA Notice of Privacy Practices policy at childrensurology.com.

I hereby give authorization for payment of insurance benefits to be made directly to Pediatrix Urology of Central Texasfor services rendered**.**
**<u>I understand that I am financially responsible for all charges whether or not they are covered by insurance</u>**.

In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is valid as the original.

Name of Patient: * _____

Signature of Patient (or responsible party if a minor): * _____ Date: * _____