Stonebrook Family Medicine
Mona Chacko M.D.

8200 Stonebrook Parkway, Suite #100
Frisco, Texas 75034
Phone: (972) 712-1911 Fax: (972) 712-1909

CHILD/ADOLESCENT PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Age: _____ Gender: ☐ M ☐ F ☐ Preferred: _____

Street Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Race: (Optional) ☐ Decline ☐ White ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Other_____

PARENT INFORMATION

Mother's Last Name: _____ First Name: _____ MI: _____

Street Address: (if different) _____ Apt #: _____ City: _____

State: _____ Zip: _____ Primary Phone: _____ Cell Phone: _____

Mother's DOB: _____/_____/_____ Email: _____

Place of Employment: _____ Work Phone: _____

Father's Last Name: _____ First Name: _____ MI: _____

Street Address: (if different) _____ Apt #: _____ City: _____

State: _____ Zip: _____ Primary Phone: _____ Cell Phone: _____

Father's DOB: _____/_____/_____ Email: _____

Place of Employment: _____ Work Phone: _____

EMERGENCY CONTACT

Full Name: _____ Relation: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____
Telephone: _____
Insured's ID#: _____
Group#: _____
Policy Owner's Name: _____
DOB: ___/___/___ Relationship: _____
Insured's Email: _____

Secondary Insurance: _____
Telephone: _____
Insured's ID#: _____
Group#: _____
Policy Owner's Name: _____
DOB: ___/___/___ Relationship: _____
Insured's Email: _____

Stonebrook Family Medicine will file your insurance as courtesy. It is to your advantage to become familiar with your health insurance benefits

Patient/Guardian Signature: _____ Date: _____

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Pediatric Questionnaire

Patient's name: _____DOB:_____ Today's Date: _____
Mother's name: _____ Age: _____
Father's name: _____Age: _____

A. PREGNANCY AND BIRTH:

1. Was the baby on time? Y N
2. What was the birth weight? _____lbs._____oz
3. Did the baby have trouble starting to breathe? Y N
4. Did the baby have any trouble while in the hospital (jaundice, infection, other?) Y N

B. PAST MEDICAL HISTORY:

1. Date of last Dental check-up? _____
2. Has child had **allergic** reactions to any medications, food, insect bites? Y N
   Which Ones? _____
3. Any hospitalizations other than for birth? Y N
4. Any surgeries?_____
   _____
5. Is child on medications? _____
   _____

C. DEVELOPMENT/BEHAVIOR:

1. At what age did child sit alone? _____
2. At what age did child walk alone? _____
3. Did your child say words by the time he/she was 1 years old? Y N
4. Does child have trouble sleeping? Y N
5. What grade is child in? _____
6. What school/daycare?_____
7. Does child get along with other children? Y N
8. Does your child have any of the following?
   ___Bed wetting ___Bad temper
   ___Problems w/discipline ___Nightmares
   ___Speech Problems ___Other

D. SAFETY/ENVIROMENT

1. Is there a working smoke alarm on each floor in the house? Y N
2. Does your child always use a car seat/ seat belt when riding in the car? Y N
3. Are there any smokers in the household? Y N
4. Does your child always wear a helmet when riding his/her bicycle or rollerblading? Y N

E. FEEDING AND NUTRITION:

1. Is child's appetite usually good? Y N
2. Does he/she take vitamins? Y N

F. PLEASE GIVE US A COPY OF IMMUNIZATION RECORDS

G. REVIEW OF SYMPTOMS:

1. Any ear trouble or hearing loss? Y N
2. Any eye problems? Y N
3. Has child had problems with teeth/gums Y N
4. Does child have frequent colds/sore throats? Y N
5. Is there asthma, pneumonia, recurrent cough? Y N
6. Does your child have a heart murmur or any heart problems? Y N
7. Does child have problems with urination? Y N
8. Does child have problems with diarrhea/ constipation? Y N
9. Have there been any convulsions or other problems with nervous system? Y N
10. Any eczema, hives, other skin conditions? Y N
11. Has child ever been anemic? Y N
12. Please list any other medical problems:
    _____

If you (P) or a member of your family, Father (F), Mother (M), Sibling (S), or Children (C), or Grandparents (GP), have had the following illnesses or problems, list the appropriate initials.

H. FAMILY HISTORY:

(mark if present in any of your child's siblings, aunts/uncles, first cousins)

___Spina Bifida
___Cancer (type)_____
___Cleft lip/palate
___Hearing loss/deafness
___Heart disease/defect
___Neurofibromatosis
___Mental Retardation
___Neurological Disorder
___Mental Illness
___Tuberculosis
___Hay fever
___Sickle Cell anemia
___Muscle disorder
___Skin disease
___High blood pressure
___Urinary tract abnormality
___High cholesterol/triglycerides
___Brain abnormalities (includes Hydrocephaly)
___Anemia (includes Thalassemia)
___Patient's mother was exposed to DES
___Other birth defects/malformations/problems?
___Vision/Eye Problems
___Cerebral Palsy
___ADD/learning disorder
___Convulsions
___Infertility
___Limb defects
___Down Syndrome
___Cystic Fibrosis
___Short stature (<5')
___Diabetes
___Drug/Alcohol problems
___Bleeding disorder
___Kidney disease
___Genital Abnormality
___Asthma
___AIDS (HIV)
___Chromosome abnormality

Please list age, sex, and health problems of brothers and sisters (are they living?):

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Stonebrook Family Medicine

New Patient Record

Pediatric Name: _____ Sex: M F

Today's Date: _____

Date of Birth: _____/_____/_____

Medical Illnesses (Please list any chronic medical illnesses or conditions.)

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____

Current Medication and Dosage (Prescriptions, over the counter, Herbal medication)

Surgeries (**please list the year**)

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____

Current Allergies or Sensitivities

List anything you are allergic to and describe how it affects you.

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____

□ **Please check box to give consent for doctor to access your pharmacy's medication list.**

***Pharmacy Name*: _____ (*cross streets*) _____**

***Pharmacy Phone*: _____ *City* _____**

Parents are: ☐ Married ☐ Living Separately ☐ Divorced

Child Lives with: ☐ Mother and Father ☐ Mother Only ☐ Father Only

☐ Adoptive Parents ☐ Other (please explain) _____

School Name/City: _____ **Phone:** _____

Current Year in School: _____ Enrolled ☐ Full Time ☐ Part Time

Work History: (*15 yrs. or older*) Are you currently employed? ☐ Yes ☐ No

If yes, current employer: _____

Personal Habits	**Never**	**Sometimes**	**Often**
Regular Exercise (3 to 4x wk)			
Wear Seat Belt			
Brush Teeth (twice daily)			
Sleep Well			
Eat Balanced Meals			
Happy with Life			
Feel Lonely			
Feel Anxious/Nervous			
Use Drugs			
Smoke Cigarettes / Cigars Chew Tobacco		Cigarettes per day _____ How many years_____	
Drink Alcohol		Frequency_____ Quantity_____ Type_____	

Family Medical History

Health Is

Relative	Age	Good	Poor	Deceased
Father	____	□	□	□
Mother	____	□	□	□
Brother	____	□	□	□
Sister	____	□	□	□

Cause(s) of Death: _____

_____

_____

If you (P) or a member of your family, Father (F), Mother (M), Grandmother (GM), Grandfather (GF), Brother (B), Sister (S) have had the following illnesses or problems list the appropriate initials:

Allergies _____
Asthma _____
Eczema, Rashes _____
Thyroid Problems _____
Lung Problems _____
Heart Diseases _____
Heart Attack_____
Cholesterol Problem _____
High Blood Pressure _____
Blood Clots_____
Stomach/Intestinal Problems _____
Ulcer_____ Crohn's_____
Liver Diseases _____
Kidney Problems _____
Diabetes _____
Cancer: Breast _____Colon_____
Prostate _____Other_____
Anemia or Blood Diseases _____
Epilepsy _____
Mental Illness _____
Depression _____
Suicide Attempt _____
Alcohol/Drug Problem _____
Arthritis _____
Osteoporosis _____
Stroke_____
Alzheimer's_____
Other_____

Stonebrook Family Medicine Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Stonebrook Family Practice respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these
services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
- medical quality review by your health plan;
- accounting, legal, risk management, and insurance services;
- audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make
this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact: office manager at (972)-712-1911

Our Responsibilities

We are required to:

- Keep your protected health information private; Give you this Notice; Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our website (www.stonebrookfp.com) to download the most recent copy.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may *contact* office manager at (972)-712-1911. If you believe your privacy rights have been violated, you may discuss your concerns with

any staff member. You may also deliver a written complaint to office manager at (972)-712-1911. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
- to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- to public health or legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information and Additional Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.
- We provide patients the opportunity to communicate with us via electronic means (e-mail, fax, etc.). These communications are not encrypted. If you choose to communicate with us via e-mail please note that we cannot ensure the confidentiality of the information contained in e-mail messages. For example, most employers have access to employee email content so if you use your work email, your employer may be able to read the messages sent to/from our office.

Web Site

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.stonebrookfp.com

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting office manager at (972)-712-1911.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I have been offered a copy of the Notice of Privacy Practices. I understand that this notice is also available for my review at www.stonebrookfp.com

_____

Print Patient Name

_____ _____

Patient or legally authorized individual signature Date and Time

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

A copy of this form will be retained in your medical record.

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FINANCIAL POLICY

1. We will file insurance for any PPO, HMO, or other managed care plans with which we are under contract. All co-payments and/or deductibles must be paid at the time of service. It is your responsibility to make sure Dr. Mona Chacko is in your provider network and your PCP, if applicable. If we are not on contract with your insurance, payment is due at time of service.

2. Note to divorced parents: Payment is the responsibility of the parent who brings the child into the office for treatment, regardless of the terms outlined in the divorce decree. The divorce decree is a matter between the divorced parents and the courts and we cannot be placed in the middle.

3. There will be a thirty dollar ($30) fee assessed for any returned check.

4. 24 hour notice is required for canceling an appointment or a $40.00 service fee may apply.

5. Your insurance policy is a contract between you and your insurance company. It is impossible for our office staff to know all the details of each insurance plan. It is important that you know your coverage and your policy provisions. State law requires your insurance carrier to process your claim within 45 days. If they fail to do so, you will be responsible for paying all charges within 45 days from the date of service. I understand that if there are any changes in my insurance coverage, I will notify the business office 2 days prior to my next appointment or the visit will be self-pay or rescheduled.

6. If your account is placed with a collection company for non-payment, there will be a collection service fee added to your account.

7. I understand that it is my responsibility to keep track of my medication supply. I understand that I should request refills during regular office hours and that request received will not be called into the pharmacist until the next business day.

HMO and POS Patients Only

1. **Precertification of Emergency, Hospital Care** - HMO patients with Dr. Chacko as Primary Care Physician. We must be notified within 48 hours of any hospital admission or services that you have received outside of our office. Failure to do so may result in a reduction of benefits. We will not be responsible for any reduction of benefits and we will not retroactively approve any emergency care that we were not notified of within the allotted time frame.
   _____
2. **Referrals**: One of the physicians at Stonebrook Family Medicine must see all patients whose insurance plan requires a referral to see a specialist. No phone referrals will be given. This is the policy of your insurance plan, not our office. Please allow three days for the referral to be processed by your insurance company. We cannot obtain retroactive referrals from your insurance company. _____

Initial the blanks above indicating you agree to payment and referral policy.

AUTHORIZATION

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Dr. Chacko. This assignment will remain in effect until revoked by me in writing. A photocopy of this policy will have the same validity as the original.

_____ _____

Patient's signature Date

Records Release to
Stonebrook Family Medicine

8200 Stonebrook Pkwy #100, Frisco Texas 75034
Phone: 972-712-1911/ Fax: 972-712-1909

Patient Legal Name: _____
FIRST MIDDLE LAST

Address: _____
ADDRESS

_____
CITY STATE ZIP

Date of Birth _____
MONTH DAY YEAR

PREVIOUS PHYSICIAN INFORMATION

_____
FACILITY OR COVERED ENTITY

_____ _____
CITY STATE

_____ _____
PHONE FAX

I hereby give my permission to disclose medical record information and/or protected information of the patient listed above to STONEBROOK FAMILY MEDICINE.

Records Requested:

- ☐ All records
- ☐ Labs, Xrays, and Physicals only
- ☐ Other _____

_____ I acknowledge, and hereby consent to such, that the release information may
INITIAL contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

Expiration: This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon the expiration date of event given here.

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to Stonebrook Family Medicine receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.

Copy fees/charges will comply with the Texas Health and Safety Code, Chapter 241 and all other laws and regulations applicable to release of information.

I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.
I have read the above and authorize the disclosure of the protected health information as stated.

_____
DATE SIGNATURE RELATIONSHIP TO PATIENT