Hummingbird Pediatrics Patient Registration

Name of Patient:

_____

Last Name First Name Middle Initial Birthdate:

Home Address: _____

City: _____, Texas Zip code: _____ Phone number: (_____)_____

Ethnicity: Hispanic ( ) Non-Hispanic ( ) Race: _____

Parent Email: _____

I hereby acknowledge that I have read, understand and agree with the Immunization Policy for Hummingbird Pediatrics. Initials of Patient/Guardian _____

I hereby acknowledge that I have read of the Hummingbird Pediatrics Notice of Privacy Practices/HIPPA policy. Initials of Patient / Guardian: _____

I consent to Telemedicine visits, by phone or video, with my childs provider when available. YES/NO

May we phone, email, or send a text to you to confirm appointments? YES / NO

May we leave a message on your answering machine at home or on your cell phone? YES / NO

May we send electronic prescriptions to a pharmacy of your choice? YES / NO

I have read the Financial policy and agree to abide by its terms, as well as authorize my insurance company to forward related payment and benefits directly to the physician's office. Initials of Patient / Guardian:

_____

I hereby acknowledge that I have read of the Hummingbird Pediatrics Office policy and had the opportunity to ask questions. Initials of Patient / Guardian: _____

By my signature below, I grant consent for Immtrac registration. I wish to include my child's information in the Texas immunization registry. Initials of Patient / Guardian: _____

I voluntarily authorize and consent to the medical care, treatment, and diagnostics tests that the providers of Hummingbird Pediatrics and their designated associates or assistants believe are necessary. Initials of Patient / Guardian: _____

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

_____

Name of Person Relationship Phone Number

_____

Name of Person Relationship Phone Number

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Hummingbird Pediatrics Immunization Policy Statement

At Hummingbird Pediatrics we believe vaccines prevent serious illness and save lives. For this reason, we require all our patients to be vaccinated, following the vaccine schedule recommended by the Centers for Disease Control and the American Academy of Pediatrics.

Based on all available literature and current studies, vaccines do not cause autism or other developmental disabilities. Thimerosal, a preservative that had been in vaccines for decades but is no longer in any vaccine we administer, does not cause autism or other developmental disabilities.

Please be advised that delaying or breaking up the vaccines to give one or two at a time goes against expert recommendations. This can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Hummingbird Pediatrics. If you should decide not to vaccinate your child despite all our efforts, we request that you find another health care provider who shares your views.

Hummingbird Pediatrics Request for Medical Records

2306 N Alexander Dr., Baytown, TX 77520

Phone: (281) 628-7442 / Fax: (281) 837-7156

Email: Hummingbirdpediatrics@gmail.com

*** Please mail or fax to address or number above ***

Today's date: _____

Patient Name: _____

D.O.B: _____ / _____ / _____

Parent Name: _____

Address: _____

City: _____ State: TX Zip code: _____

Cell #: (_____) _____

I, _____ hereby request to obtain / release medical information from

Name of Previous Clinic or Doctor: _____

Address: _____

City: _____ State: _____ Zip code: _____

Office number #: _____ Fax number #: _____

Please mail or only shot record and problem list due to patients/parents request for PCP Change

Signature: _____ Date: _____/_____/_____