DATE:________________________

() J. Christopher Meriwether, M.D.
() Michael S. Fontenot, M.D., P.A.

1331 Bandera Hwy, Suite 10
Kerrville, TX 78028

Personal Information:

Patient Name ______________________

Birthday ______________________

() Male () Female

S.S.N. ______________________

Address ______________________

City/State/Zip ______________________

Home Phone ______________________

Cell Phone ______________________

Mom Name ______________________

Mom Address ______________________

Mom Birthday ______________________

Mom SSN ______________________

Mom Work # ______________________

Dad Name ______________________

Dad Address ______________________

Dad Birthday ______________________

Dad SSN ______________________

Dad Work # ______________________

Person Responsible for bill
() Mother () Father
() Other name______________________
Billing address (if different)

____

Emergency Contact
Name ______________________
Phone ______________________

Insurance: ______________________
(attach card)

Referred by ______________________

Former Physician ______________________

Preferred Pharmacy______________________

Past Medical History: (Use back if necessary)

Birth:
() Full Term () Premature
() Vaginal delivery () C. Section
Birth Weight: ____________

Hospitalizations: () None

Year	Reason

Surgeries: () None

Year	Reason

Chronic Conditions: () None

____

____

Prescription Meds: () None

____

____

____

Development Problems:
Language: () Yes () No
Motor: () Yes () No
Drug Allergies: () Yes () No

____

____

Family History: (Seizures, Asthma, Allergies, Kidney disease, etc…)

Relation **Disease**
() Sibling ______________
() Parents ______________
() Aunt/Uncle ______________
() Grandparent ______________

Social History:
Who lives at home ______________

____

Smokers? () Yes () No
Pets? () Yes () No ______________

Administrative

Kerrville Pediatrics

J. Christopher Meriwether, M.D.
Michael S. Fontenot, M.D.

1331 Bandera Hwy, Suite 10
Kerrville, TX 78028
830-257-1440

GENERAL CONSENT FOR TREATMENT

The undersigned parent or guardian of ________________________________ knowing that the child is suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care into such medical, surgical, or other services under the general and specific instructions of either J. Christopher Meriwether, M.D. or Michael S. Fontenot, M.D., P.A. or their assistants, or their designate as is necessary in their judgment.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as a result of treatments or examination by either J. Christopher Meriwether, M.D. or Michael S. Fontenot, M.D.

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, do hereby authorize J. Christopher Meriwether, M.D., and/or Michael S. Fontenot, M.D., P.A. to release to my insurance company any and all medical information, of whatever nature, now in their possession or later acquired, from whatever source, which pertains to or relates to my child's medical care. This authorization in consent is granted for the sole and limited purpose of facilitating the quality of medical care conducted by J. Christopher Meriwether, M.D., and/or Michael S. Fontenot, M.D., P.A. I am releasing those rights and claims of confidentiality and privilege concerning the information described which may otherwise exist, when used for the purposes described. I further understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the office of J. Christopher Meriwether, M.D. or Michael S. Fontenot, M.D., PA, provided however, that any such withdrawal will not affect any information disclosed prior to receipt by the office of the written notice of withdrawal.

PAYMENT POLICY

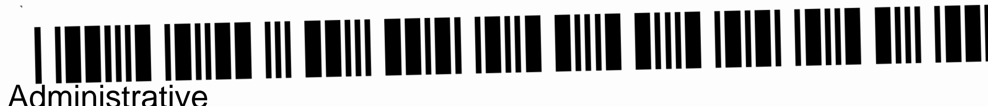
All professional services rendered or charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each service unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurers.

AUTHORIZATION OF PAYMENT

I authorize release of any medical information necessary to process a claim. I also request payment of benefits either to myself or to the party who accepts assignment.

________________________________ ________________________
Signature Date

____
Witness



Kerrville Pediatrics

J. Christopher Meriwether, M.D.
Michael S. Fontenot, M.D.
Teresa Farley, MSN, RN, CPNP

1331 Bandera Hwy, Suite 10
Kerrville, TX 78028
830-257-1440

Date: ______________________________

Children's Names: ______________________________
____
____
____

Acknowledgment of Review of Notice of Privacy Practices

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

____
Parent or Guardian signature

____
Relationship