DR. EISNER PEDIATRICIAN

Welcome to our office!

PATIENT INFORMATION: *(please list all patients, if you have more than one child.)* *Today's date:* _____

Name	D.O.B	Sex	S.S	Biological, Step-Child, or Adopted?	Have you signed Immtrac consent?

** ImmTrac, the Texas immunization registry, is a no-cost service offered by the Texas Department of State Health Services (DSHS). It is a secure and confidential registry available to all Texans. ImmTrac safely consolidates and stores immunization information electronically in one centralized system. Available for all doctors, Hospitals, and schools, should you lose or not have shot record with you. Dr. Eisner strongly encourages you to sign up for ImmTrac if you have not already done so.

(If more than one child is being enrolled, these next sections only need to be filled out once.)

Parent's information

Mothers Full Name: _____ Maiden Name: _____
Home address: _____Email:_____
Home Phone: _____Cell Phone: _____Work Phone: _____
D.O.B:_____ SSN #:_____ TDL#: _____ Marital Status: M___ S___ D___ W___
Employer_____ Position: _____
Work Address: _____

Fathers Full Name: _____
Home address: _____ Email: _____
Home Phone: _____Cell Phone: _____Work Phone: _____
D.O.B: _____ SSN #:_____ TDL#: _____ Marital Status: M___ S___ D___ W___
Employer_____ Position: _____
Work Address: _____

Primary responsible person, and/or Primary Holder on Insurance

Full Name: _____ Relationship: _____
Home address: _____Email:_____
Home Phone: _____Cell Phone: _____Work Phone: _____
D.O.B:_____ SSN #:_____ TDL#: _____ Marital Status: M___ S___ D___ W___
Employer_____ Position: _____
Work Address: _____

Insurance Policy: _____ Policy holders name: _____
2nd Insurance policy: _____ Policy holders name: _____

Emergency Contact:
Name: _____ Phone: _____ Relationship: _____

How were you referred to our office? _____

Patients Name: _____
Date Of Birth: _____

Social History

Is there anything personal you would like to discuss with Dr. Eisner only? ☙ *Y* ☙*N*

Who does the patient live with? (Please check all that apply.)
___Both parents' ___Mother only ___Father only ___ Step-Mother ___Step-Father ___ Grandmother ___Grandfather
___Other, please explain:_____

Total adults living in the home_____ Total children living in the home_____

Please circle all that apply:

Questions?	Who does the question Apply too and how often?
Does anyone in the home use Tobacco?	Patient_____ Mother_____ Father_____
Does anyone in the home drink Alcohol?	Patient_____ Mother_____ Father_____
Does anyone in the home use Recreational Drugs?	Patient_____ Mother_____ Father_____
Does anyone in the home have psychiatric problems?	Patient__ Mother__ Father__ Other:_____

Please check all that Apply to Patient:
☙ Adjustment or Reaction to new child
☙ Adjustment to new living arrangements
☙ Death in the family
☙ Recent Break-Up
☙ Parent Divorce/Separation
☙ Bullying at School
☙Other: _____
Please explain:_____
_____

This next section only needs to be filled out once.
If more than one new patient is being enrolled with same biological mother.

Mother of Patient: Pregnancy History

Total # of pregnancies: _____ Total children born: _____ Any miscarriage / Abortions: _____

Vaginal or C-sections? _____

Any Complications? _____
_____
_____
_____
_____

Children's Medical/Surgical History

Include all current and past medical problems, surgeries, hospitalizations and medications.
Include all children including step-children.

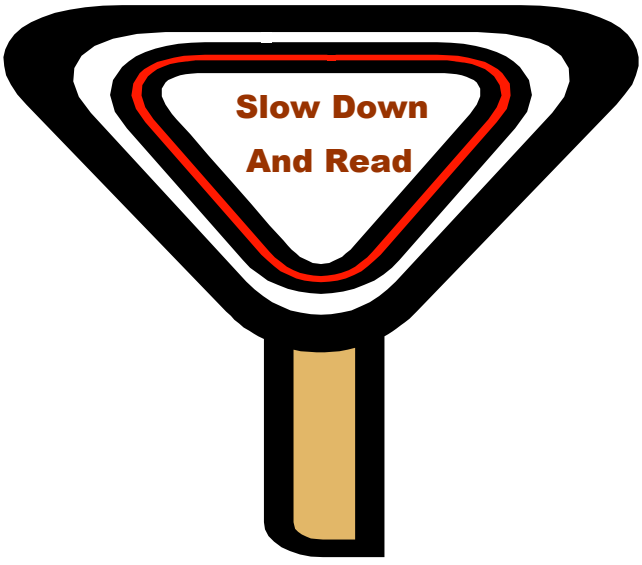
Childs Name: _____
_____

Childs Name: _____
_____

Childs Name: _____
_____

Childs Name: _____
_____

Childs Name: _____
_____



This next section may only be filled out once

If more than one new patient is being enrolled with same biological parents

MATERNAL (Mother's) FAMILY HISTORY

Please list diseases or illness on the biological mother's side of the family.
Include name and DOB only for those relatives with health problems.

*****Include distant relatives under other only if they have a rare disease*****

(Include family member even if deceased)

Relation to Patient	D.O.B	Age of Death:	First Name	Last Name	Medical Problems
Children's Mother					
Mother's Mother **(Children's Grandmother)**					
Mother's Father **(Children's Grandfather)**					
Mother's Brother/Sister **(Children's Uncle/Aunt)**					
Mother's Brother/Sister **(Children's Uncle/Aunt)**					
Mother's Brother/Sister **(Children's Uncle/Aunt)**					
Mother's Brother/Sister **(Children's Uncle/Aunt)**					
Mother's Brother/Sister **(Children's Uncle/Aunt)**					
Mother's Brother/Sister **(Children's Uncle/Aunt)**					
Mother's Niece/Nephew **(Children's Cousin)**					
Mother's Niece/Nephew **(Children's Cousin)**					
Mother's Niece/Nephew **(Children's Cousin)**					
Mother's Niece/Nephew **(Children's Cousin)**					
Mother's Niece/Nephew **(Children's Cousin)**					
Mother's Niece/Nephew **(Children's Cousin)**					
Other					
Other					
Other					

This next section may only be filled out once
If more than one new patient is being enrolled with same biological parents

Paternal (Father) FAMILY HISTORY

Please list diseases or illness on the biological Father's side of the family.
Include name and DOB only for those relatives with health problems.
Include distant relatives under other, if they have a rare disease*
(Include family member even if deceased)

Relation to Patient	D.O.B	Age of Death	First Name	Last Name	Medical Problems
Children's Father					
Father's Mother **(Children's Grandmother)**					
Father's Father **(Children;s Grandfather)**					
Father's Brother/Sister **(Children's Uncle/Aunt)**					
Father's Brother/Sister **(Children's Uncle/Aunt)**					
Father's Brother/Sister **(Children's Uncle/Aunt)**					
Father's Brother/Sister **(Children's Uncle/Aunt)**					
Father's Brother/Sister **(Children's Uncle/Aunt)**					
Father's Brother/Sister **(Children's Uncle/Aunt)**					
Father's Niece/Nephew **(Children's Cousin)**					
Father's Niece/Nephew **(Children's Cousin)**					
Father's Niece/Nephew **(Children's Cousin)**					
Father's Niece/Nephew **(Children's Cousin)**					
Father's Niece/Nephew **(Children's Cousin)**					
Father's Niece/Nephew **(Children's Cousin)**					
Other					
Other					
Other					

Website: www.doceisner.com / Diana Eisner, M.D.

Welcome and thank you for choosing Dr. Eisner for your medical care. We are committed to providing you with quality medical care, our professional fees have been determined through careful consideration, and we believe these fees are reasonable and reflect other area physician's charges. We are pleased to discuss with you any questions you may have concerning your bill. Providing quality care is our primary concern.

Method of Payment: Dr. Eisner accepts personal checks, cash, debit cards or credit cards (Discover/Master Card/Visa) for payment of your medical services. A $30.00 fee will be accessed to your account for all returned checks.

Indemnity and Private Insurance Policies: Dr. Eisner will file claims directly with your insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee your insurance will pay for services. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service. **REMEMBER: You are responsible for paying your bill or seeing to it that your bill gets paid.**

Contracted Managed Care Plans (HMO, PPO, POS, EPO, etc.): Each time you make an appointment with Dr. Eisner it is your responsibility to make sure the physician is currently under contract with your plan. Verification of your plan benefits/coverage is required. Often this verification requires us to share the reason for your visit with a managed care plan. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

We allow 45 days from the date a claim was filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for the entire balance without further notice. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, co-payments, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Office Charges and/or Fees: The following charges and/or fees will be accessed to your account when incurred.

- If appointments are missed more than two times without advance notification: **$25.00**. Following missed appointments: **$25.00**/each.
- No advance notification when running more than 15 minutes late for an appointment: **$10.00**.
- Re-writing the same ADHD prescription or having to complete paperwork twice either because the prescription was not picked up/filled in a timely manner or some other patient responsibility not met: **$25.00**.
- Copies of immunization records: **$10.00** (excludes forms completed at no charge at time of routine office visits or well child care visits).
- Completion of forms, such as camp, day care or athletic activity participation forms: **$10.00 - $25.00** (Only if filled out more than once).
- Copying records: **$25.00**

I have read and understand the above terms and conditions and will verify so by giving my signature.

Signature:_____ **Date:**_____