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 and schools, should you lose or not have shot record with you.

(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? ____
____
____
____

<u>Children's Medical History</u>

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

Childs Name: ____

____

Childs Name: ____

____

Childs Name: ____

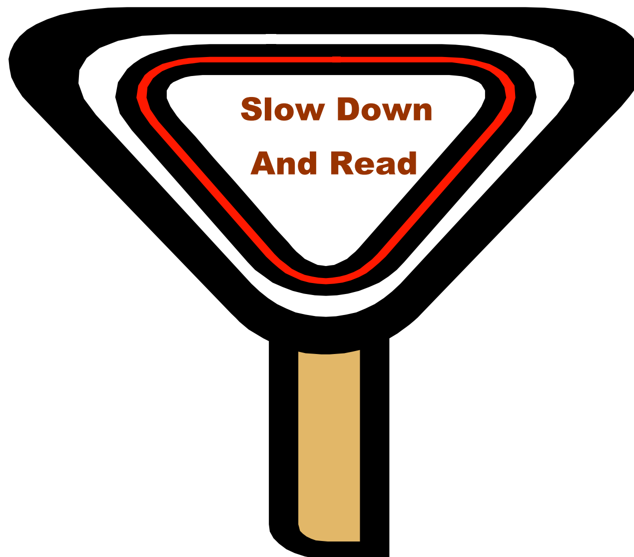
____

Childs Name: ____

____

Childs Name: ____

____



<u>FAMILY HISTORY NEXT PAGE</u>

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

Relation to Patient	First Name	Last Name	Current and Past Medical Problems (Include family member even if deceased)
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			

Paternal (Father) FAMILY HISTORY

Please list diseases or illness on the biological Father's side of the family.

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

Relation to Patient	**First Name**	**Last Name**	**Current and Past Medical Problems (Include family member even if deceased)**
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. Providing quality care is our primary concern.

Providing Care: I, the undersigned, hereby consent to and permit Dr. Diana Eisner and her staff to provide treatment and care as may be deemed necessary for the patient.

Indemnity and Private Insurance Policies: Our office will file claims directly with your insurance carrier for services. Insurance verification does not guarantee payment. 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.

Medical Records: A summary of medical care, growth records/charts as well as Immunization records are available AT NO CHARGE by logging in to our patient portal. There will be a $25.00 fee for an entire medical file.

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

Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:

Signature:______________________________ Date:______________