12121 Richmond Ave, Suite 307
Houston, TX 77082

M. Haroon Siddiqui M.D., P.A.
Pediatrics and Adolescent Medicine

Phone (281) 558-5570
Fax (281) 558-5081

PATIENT INFORMATION FORM

Patient's Name _____ Birth Date _____
(Nombre del paciente) (Fecha de Nacimiento)
Age _____ Sex _____ Social Security# _____
(Edad) (Sexo) (Seguro Social)
Home Address _____ Apt# _____
(Direccion de casa)
City _____ State _____ Zip _____ Home Phone _____
(Ciudad) (Estado) (Zona Postal) (Numero de casa)
Cell Phone _____
(Numero de celular)

Race : White / Black / Hispanic / Asian/ Other

Ethnicity: Hispanic or Latino / Not Hispanic Preferred Language _____

EMAIL ADDRESS: _____

Mother's Name _____ Father's Name _____
(Nombre de Madre) (Nombre de Padre)

Insurance name : _____ Ins Address _____

Insurance ID : _____ Insurance Phone # _____

Insured's Social Security _____-_____-_____ Insured's Driver's License _____
(Seguro Social del asegurado) (Lisencia del asegurado)
Insured Employed By _____
(Nombre del empleado)
Business Address _____ Suite _____
(Direccion de trabajo)
City _____ State _____ Zip _____ Phone Number _____
(Ciudad) (Estado) (Zona Postal) (Numero de trabajo)

Emergency Phone Number _____ Contact Name _____
(Numero de emergencia) (Persona de contacto)
Pharmacy Name _____ Pharmacy Number _____
(Nombre de farmacia) (Numero de farmacia)
Pharmacy Address: _____

Patient has any other Health Insurance: YES___ NO ___ Insurance Name: _____

Insurance ID _____

Treatment of minor
(Permiso de dar tratamiento a el/ la menor)

Signature _____ Date _____
(Firma) (Fecha)
I hereby authorize M. H. Siddiqui, M.D., to furnish information to my insurance company concerning my illness and treatment. I understand that I am responsible for any amount not covered by my insurance company.

Signature _____ Date _____
(Firma) (Fecha)
Medical Release Authorization
I certify that the information furnished is true and correct. I know that it is a crime to fill out this form with the facts that are false or to leave out facts I know are important.

Signature _____ Date _____
(Firma) (Fecha)

If your child needs medical, dental or hospital services, a parent must give permission. It's the law. What about times when you cannot be reached for permission? A child may be treated without parental consent when a physician determines a true emergency exists. That means the doctor determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

You can prepare for unexpected care your children might need when you are away from home. To do this, make sure babysitters know how to reach you at all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you by permitting your child to be treated if unexpected care is needed.

This is a legal document. With it you may appoint relatives, friends, teachers, clergy, neighbors- anyone who is over 18 years of age- to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions, when you know it will be hard to contact you.

Fill out this form, give it to the adult(s) you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person- physician, dentist or hospital representative.

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Minor(s)	DOB	Allergies/ Special Conditions

I/ We, being the parent(s) or legal guardian(s) of the above named minors(s), do hereby appoint:

Name	Address	Phone #

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minors(s) during the period of my/ our absence, from: _____

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

_____ _____
Signature of Parent / Guardian **Address**

_____ _____
Signature of Parent / Guardian **Address**

_____ _____
Signature of Witness **Address**

_____ _____
Signature of Witness **Address**

Hospitalization Coverage for above Named Minor(s)

Insurance Company or Government Program ID or Contact #

_____

Family Physician:
Name: _____ **Phone:** _____

All articles and any forms, checklists, guidelines and materials are for generalized information only, and should not be reviewed or referred to as primary legal sources nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. They are intended as resources to be selectively used and always adapted – with the advice of the organization's attorney – to meet state, local, individual organizations and department needs or requirements. They are distributed with the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services.

Revised 09-25-06

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Advance Practice Nurse and Physician Assistant
Consent for Treatment

This facility has on staff an advance practice nurse(NP) and Physician to assist (PA)in the delivery of medical (may indicate specialty) care.

An advance practice nurse and PA is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

A PA is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of an advance practice nurse for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Name:_____Date _____

Signature:_____Witness: (optional)_____

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Pediatric History

Date of Birth: ____/____/____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Father's Name: _____
Mother's Name: _____

Employer:
Mother: _____
Position: _____
Phone: _____
Father: _____
Position: _____
Phone: _____

Pregnancy Complications:

	Yes	No
Prenatal Care	___	___
Pregnancy less than 9 months	___	___
High blood pressure	___	___
Toxemia	___	___
Medications: (if yes, list)	___	___
Maternal Substance Use:	___	___
Other: _____		
Bleeding (if yes, what month)	___	___
Serious illness/Infections	___	___
Previous miscarriage	___	___

Other problems (explain): _____
C-sections: (if yes, why?), Vaginal, Forceps_____
Other: _____ Breast: _____Formula: _____

Birth History

Place of birth(hospital name): _____
Birth weight: _____ Length: ____
Length of labor_____
Adopted: No____ Yes_____

Problems:

Jaundice	Yes____	No___
Hearing Test pass	Yes____	No___
Breathing problems	Yes____	No___
Antibiotics	Yes____	No___
Hepatitis B	Yes____	No___
Other:	Yes____	No___

Development: At what age did your child?

Smile: _____ Roll over: _____Sit alone: _____First tooth: _____ Immunizations Current Yes___No___
Walk alone: _____ 1st word with meaning: _____ Use 3 word sentence: _____
Bladder trained: _____ Bowel trained: _____Ride Tricycle: _____ Tie Shoes: _____

List medication child takes routinely:

1) _____
2) _____
3) _____
4) _____

Hospitalization & Operations:

1) _____
2) _____
3) _____
4) _____

Child's Illness:	Yes	No	Date
Whooping cough	___	___	_____
Measles	___	___	_____
Rubella	___	___	_____
Mumps	___	___	_____
Chickenpox	___	___	_____
Scarlet fever	___	___	_____
Meningitis	___	___	_____
Pneumonia	___	___	_____
Diabetes	___	___	_____
Rheumatic fever	___	___	_____
Convulsions	___	___	_____
Bed wetting	___	___	_____
Kidney disease	___	___	_____
Sickle Cell	___	___	_____
Allergies	___	___	_____
Asthma	___	___	_____

Serious Illness:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

School problems? Yes____ No ____

ALLERGIES TO MEDICATIONS:

_____
_____
_____

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Pediatric History : FAMILY HISTORY

	ALIVE	DEAD	DISEASES		ALIVE	DEAD	DISEASES
Mother	____	____	_____	Maternal Grand Mother	____	____	_____
Father	____	____	_____	Maternal Grand Father	____	____	_____
Brother(s) 1)	____	____	_____	Paternal Grand Mother	____	____	_____
2)	____	____	_____	Paternal Grand Father	____	____	_____
3)	____	____	_____	Maternal Uncle	____	____	_____
4)	____	____	_____	Maternal Aunt	____	____	_____
Sister(s) 1)	____	____	_____	Paternal Uncle	____	____	_____
2)	____	____	_____	Paternal Aunt	____	____	_____
3)	____	____	_____				
4)	____	____	_____				

Social:	**Yes**	**No**
Smokers in Household?	_____	_____
Smoking Status (13 years and older)	_____	_____
Pets: (list)	_____	_____

_____
_____
_____

Is there anything else the doctor should know to better take care of your child?

_____
_____
_____
_____

Date: _____ Signature/Title: _____ Signature/Title _____

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HIPPA CONSENT

CONSENT TO LEAVE MESSAGE

Patient Name: _____ Date: _____

Parent Name: _____ Relationship: _____

I wish to be called at home ( ); other ( ) (check all that apply) regarding patient care and follow – up. The best telephone number(s) to reach me are:

_____home _____other

I do ( ), I do not ( ) give permission to leave relevant medical information on my answering machine or voice mail.

I do ( ), I do not ( ) want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

_____

_____

_____ _____

Parent Signature Date

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OFFICE POLICIES

PLEASE READ THOROUGHLY

1. **LATE POLICY**: If you arrive 30 minutes past your appointment time, it is considered missed .You will have to reschedule for the next available time.

2. **NO-SHOW POLICY:** Appointments must be cancelled 6 hours prior to appointment time.

3. **VACCINATION POLICY:** Vaccination Records are required for all well-child checks and physicals. For lost or to replace immunization cards, there will be a $10.00 charge.

4. **TRANSFER POLICY:** Once your child's records are transferred to another clinic his/her file will be deactivated in our system.

5. **MEDICAL RECORD REQUEST:** There is a $25.00 charge for the first 20 pages and additional pages will have a 50c charge.

6. **VIDEO TAPING/PICTURE TAKING:** Videotaping and picture taking is NOT ALLOWED within the clinic premises.

I have read and understand this office' s policies which explain the terms and conditions of this office in regards to appointments, no-shows, vaccination records and medical record policy.

_____ _____

Patient's Name Date of Birth

_____ _____

Parent/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with you written authorization. You may revoke such authorization in writing and we are required to honor ad abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257/ Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Organization:

M. Haroon Siddiqui M.D., P.A.
12121 Richmond Avenue, Suite 307
Houston, TX 77082
Phone: (281) 558-5570
Fax: (281) 558-5081

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("***HIPAA***"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female

Telephone _____ - _____ - _____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code § 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in ImmTrac2. Once in ImmTrac2, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction; a physician, or other health care provider legally authorized to administer vaccines, for treating the child as a patient; a state agency having legal custody of the child; a Texas school or child-care facility in which the child is enrolled; and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.
An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder.
For more information, see Texas Health and Safety Code § 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.
☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.
Parent, legal guardian, or managing conservator:

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2.** **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

Stock No. C-7
Revised 02/2024

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Authorization for Release of Protected Health Information or medical record

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name: _____ Date Of Birth: _____

Social Security Number: _____

Limitations on the information you may release subject to this Release Form are as follows:
Previous Doctor's Name_____
Address:_____
Phone #_____ Fax:_____

Release my protected health information to the following person(s)/ entity:

TO: **M.Haroon Siddiqui M.D.,P.A.**
12121 Richmond Ave, Suite 307
Houston, TX 77082
281-558-5570 Fax: 281-558-5081

The reasons or purposes for this release of information are as follows:
Change of Doctor Complete record Immunization records
Other: _____

Please send all records by MAIL
Fax only shot records

This authorization shall be in force and effective until the following event and/ or date:

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing be contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

I understand that you will provide this information within 15 days from receipt of this request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Person or entity requesting the information and authorization to make the requested use or disclosure:

_____ _____

Patient signature (or parent, guardian or legal representative) Date