Peggy Wongsa, MD, FAAP
Certified by American Board of Pediatrics

NEW PATIENT REGISTRATION

Language Preference		Allergies	
Patient	First Name	Middle	Last
	DOB	Sex ☐ M ☐ F	**Home phone**
	Address where the child lives		
	City	State	Zip
	Communication through email? ☐ Yes ☐ No	Email address	
	Patient Race: ☐ Native American ☐ Native Alaskan ☐ Asian ☐ Black ☐ Pacific Islander ☐ White ☐ Black Hispanic ☐ White Hispanic ☐ Other		
	How did you hear about us?		
Guarantor	Mother/Parent	Marital status ☐ M ☐ S ☐ W ☐ D	Father/Parent	Marital status ☐ M ☐ S ☐ W ☐ D
	Name		Name	
	SSN	DOB	SSN	DOB
	Address (if different)		Address (if different)	
	Cell Phone		Cell Phone	
	Occupation		Occupation	
	Employer		Employer	
	Work Phone		Work Phone	
	Legal Guardian or Guarantor (if not a parent)	Relationship to patient		
	Name		Cell Phone	
	SSN	DOB	Occupation	
	Employer		Work Phone	
Name and phone no. of a friend or relative				
Insurance	Insurance Co.	Policy / ID No.		
	Subscriber Name		DOB	
	Customer service phone		Group No.	
	Medicaid No.	Plan		
By signing below, I acknowledge that the information I have provided is correct to the best of my ability.				
Parent /Guarantor Signature		Date		

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11302 Fallbrook Drive, Suite 305
Houston, TX 77065-4265
Tel: (281) 897-1122 Fax: (281) 897-0777

OFFICE POLICIES

Thank you for choosing Dr Peggy Wongsa as your pediatrician! Below are some policies we use to facilitate a good relationship between you and your doctor. **PLEASE READ AND INITIAL EACH ITEM BELOW.**

1. I agree to arrive on-time for my appointments with Dr. Wongsa. **I agree to contact the office at least 24 hours prior to my/the patient's appointment for rescheduling or cancellations. I understand that 3 missed appointments without 24 hrs notice will lead to my dismissal from the practice**. _____

2. I understand that Dr. Wongsa must see the patient in the office before prescribing any medication. I understand that Dr. Wongsa does not respond to pharmacy requests for prescription refills. When the prescription (with the noted number of refills) has run out, I will contact the office if the patient is still suffering from the condition diagnosed by Dr. Wongsa. _____

3. I will notify the office of changes in address, telephone number or insurance. I will bring the patient's insurance card(s) to every visit. _____

4. Many health insurance plans require collection of a co-pay or contracted percentage of services at every visit. I understand that the adult who brings the child to the office will be expected to pay at the time of service. I agree to pay a $25 fee if the full amount of the co-pay is not paid on the date of the visit. I agree to pay by cash or credit card. _____

5. I understand that I am ultimately responsible for understanding my/my dependent's health insurance benefits. The office staff's attempts to verify eligibility and benefits are done as courtesy to me only. If the office is unable to verify benefits or if my insurance company does not pay for a service, I understand that I will be financially responsible for the charges from the services rendered. _____

6. I will remit payment by check ($35 return check fee) or contact the office to pay by credit card any balances due immediately upon receipt of a patient statement. If I do not remit payment within 30 days of receipt of the bill, I agree to pay a $25 rebilling fee for every monthly statement thereafter. _____

7. If I have forms for Dr. Wonga to complete, such as WIC forms, daycare forms and preauthorization forms, I will bring these forms to be completed during an office visit. I understand that requests for completion of forms outside of office visits have a 3-5 business days turnaround time. _____

8. I understand that medical record requests, including immunization records are charged a copying fee. There is no charge for medical records faxed to another physician. All medical record requests require completion of a medical release form, which I will fill out at the office. _____

Again, we thank you for choosing us to care for your family. If you have any questions regarding our office policies, please don't hesitate to ask. Please sign below to acknowledge understanding of the entire policy and that you were provided a copy for your records.

_____

Patient Name Date of Birth Parent/Guarantor Printed Name

_____

Parent/Guarantor Signature Date

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ASSIGNMENT OF BENEFITS/AUTHORIZATION OF RELEASE

By signing the bottom of the page, I agree to the following.

I, hereby assign to Dr. Peggy Wongsa all insurance benefits, if any, for services rendered me/my dependent. I understand that I am financially responsible for the amount not covered by my health insurance plan. I also authorize the use of this signature on all insurance submissions.

I have received this office's Notice of Privacy Practices, which explains how my Protected Health Information (PHI) will be used and disclosed. I authorize the release of my health information as stated in the Notice of Privacy Practices.

For Texas Medicaid patients only: I understand that, in the opinion of Dr Peggy Wongsa, the services or items that I have requested to be provided to me beginning on the "date of first treatment" below may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

For foster care patients: I authorize the release of my medical records to my foster care agency, Children Protective Services, or other agencies having authority as requested by such parties.

CONSENT FOR TREATMENT

I, knowing that I or my dependent, (patient's name)_____ , am/is suffering from a condition requiring diagnostic, medical, or surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of ***Dr. Peggy Wongsa***, her assistants, or her designee as is necessary in her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantee has been made to me as to the result of treatments or examination by ***Dr Peggy Wongsa***.

_____

Your name Relation to patient Date of first treatment

_____

SIGNATURE

If you are not the parent, also complete the applicable sections below.

_____

Name of Patient's Mother Name of Patient's Father

_____

Name(s) of Legal Guardian(s)

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HOUSEHOLD INFORMATION

Does the patient have **siblings** in the same household at our practice? **(circle one) YES NO**

If yes, please list siblings:

First Name	Last Name	DOB

AUTHORIZATION

I authorize the following people to communicate with the office of Peggy Wongsa MD on my behalf regarding (patient's name) _____:

Full Name: _____ Relationship: _____ Phone # _____

Full Name: _____ Relationship: _____ Phone # _____

Full Name: _____ Relationship: _____ Phone # _____

Full Name: _____ Relationship: _____ Phone # _____

_____
SIGNATURE OF PARENT/ GUARDIAN DATE

_____
PRINT NAME

Peggy Wongsa, MD, FAAP

TELEMEDICINE CONSENT AND PATIENT AGREEMENT

Patient Name:_____ Date of Birth: _____

If you would like to opt-out, check this box: ☐ I would like to opt-out of this service at this time. Initial here: _____

I, (parent or guardian name)_____, parent or guardian to the above named patient, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that medical records of telemedicine services will be kept at our facility in the same format as records of in-person visits.

_____ I understand that each telemedicine visit will be scheduled and that each videoconference session will be initiated by the physician office only. I understand that Dr. Wongsa and the office staff will NOT be monitoring our telecommunications platforms for urgent medical questions. All medical questions should be directed to our phone number 281-897-1122.

_____ I understand that as with any technology, telemedicine does have its limitations. **There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see Dr. Peggy Wongsa or other medical specialists in person.**

_____ I understand that telemedicine only works with certain kinds of visits/conditions. **Dr. Wongsa will be the sole decider on what kind of condition may be evaluated or treated through telemedicine.**

_____ I understand that the **fee for telemedicine is $40.00 per session.** I agree to make the payment for this service **over the phone by credit card prior to each telemedicine session**.

> Patients using Insurance: We will attempt to verify telemedicine benefits with your insurance plan before the scheduled visit; however, the benefits quoted may not match the true coverage. Any differences in allowable amounts and the patient responsibility will be billed or refunded to you after the claim has processed. **You may be billed for additional amounts after the visit according to how your insurance plan processes the claim.**
>
> Medicaid Patients: Telemedicine is a covered benefit of Texas Medicaid. However, if the patient is not eligible at the time of service, the patient must agree the pay the self-pay amount of the service. We will bill your Medicaid plan for the telemedicine service. If the adjudication shows the service to be not a covered benefit, you will be responsible for the telemedicine fee.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I have had an opportunity to review the office's Notice of Privacy Practices.

_____

SIGNATURE Date

_____

Printed name Relationship to patient

NEW PATIENT QUESTIONNAIRE
(To be filled out by parent)

Mother's name _____ Age _____ Child's name _____
Occupation _____ Chart No. _____
Father's name _____ Age _____ Date _____
Occupation _____

If adults in the household works outside the home, what child care arrangements are made for this child? _____
_____

A. PREGNANCY & BIRTH:

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? No Yes
3. Did she take medications other than vitamins & iron? No Yes
4. Was the baby on time? Yes No
5. What was the birthweight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, others?) No Yes
   What kind? _____
   _____

B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups until now? _____
2. Date of last check-up: _____
3. Date of last dental check-up _____
4. Has your child had allergic reactions to any medications, foods, and insect bites? No Yes
5. Has your child had reactions to any immunizations? No Yes
   Which ones? _____
6. Any hospitalizations other than for birth? No Yes
   For what? _____
7. Any serious injuries? No Yes
   What kind? _____
8. Are any medications taken regularly No Yes
   Which ones? _____

C. FAMILY HISTORY:

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others _____
3. List age, sex and general health of brothers and sisters. _____
   _____
   _____
4. Have any of your children died? No Yes

D. FEEDING & NUTRITION:

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, is he/she (was he/she) breast-fed or bottle-fed? _____
6. If still on formula, which one do you use? _____
7. Does he/she take vitamins? Yes No

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throats? No Yes
5. Is there asthma, pneumonia, or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Please list any other medical problems: _____
    _____
    _____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1½ years old? Yes No
4. How does this child compare to others his or her age? _____
5. Does he/she have any trouble sleeping? No Yes
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? No Yes
8. Does he/she get along with other children? Yes No.
9. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, bad temper, problems with toilet training, hyperactivity, nightmares, speech problems, problems with discipline, others _____

G. SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other? (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor in the house? Yes No
4. Does your child always use a car seat/seat belt when riding in a car? Yes No
5. Are there any smokers in the household? No Yes
6. Are there any problems with the condition of your home? (peeling paint, insects, rats or mice) No Yes
7. Does your child always wear a helmet when riding his/her bicycle? Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS ? Yes No