Dr. Josephine Ruiz Healy M.D.

Date/Fecha _____

Phone Number: _____

Name/Nombre: _____ **DOB**/Fecha de nac.: _____ **Age**/Edad: _____

Family History/Historia Familiar

Mother/ Madre _____

Father/ Padre _____

Siblings/Hermanos	**DOB**/Fecha	**Sex**/Sexo	**Health**/Salud
1			
2			
3			
4			

Miscarriages/Abortos	**Month**/Mes	**Cause**/ Causas

***NOTE: Immediate family members**
***ATTN: Miembros inmediatos de la familia**

Asthma/Asma
Allergies/ Alergias
Diabetes
Heart cond./Cond. Cardiaca
Cancer
HBP/Presion Alta
Anemia
Others/Otros

Birth History/ Hist. del Nacimiento

Term/Termino
Premature/Prematuro
Pregnancy/Emabarazo #
Vaginal Delivery/ Parto vaginal
C-Section Delivery/ Parto por cesarea
Instruments/Instrumentos?
Labor length/Duracion
Other/ Otros
Hospital & Doctor

(Condition at birth/ Cond. al nacer)
Weight/Peso
Height/ Estatura
Apgars/Apgares
Jaundice/ Bilirubina
Convulsions/Convulciones
Deformities/Deformidades
Other/Otros

Feeding History/Hist. de Comidas

Breast/Pecho
Formula
Appetite/Apetito
Soft foods added/ Comidas suaves agregados
Allergies/Alergias
Constipation/ Estrenimiento
Vomiting/Vomito

Medications/Medicamentos

Vitamin Supp/ Vitaminas

Health History/ Historial de Salud

Last well check/Ultimo fisico
Gen. Health/Salud en gral.
Allergies/Alergias
Asthma/Asma
Sinusitis
RSV/Bronchiolitis
Bronchitis/Bronquitis
Chickenpox/Varicela
Colds/Catarros
Measles/Sarampion
Rubella/Rubiola
Mumps/Paperas
Rheum Fever/Fiebre Reum
Pneumonia/Pulmonia
Ear infections/Infecc. Oido
T&A/Tonsilectamia & Adenoides
Tonsillitis/Amigdalitis
Scarlet fever/Fiebre escarlatina
Injuries/Lesiones
Hospitalized/Hospitalizado
Other/Otro

Dev. History/Hist. del Desarrollo

Held up head/Levanto la cabeza	Mos.
Sat aided/Sento con ayuda	Mos.
Sat alone/Sento solo	Mos.
Stood aided/Paro con ayuda	Mos.
Stood alone/Paro solo	Mos.
Crawled/Gateo	Mos.
Walked/Camino	Mos.
Said words/Dijo palabras	Mos.
Sentences/Frases	Mos.
First teeth/Primeros dientes	Mos.

At HOME/ En CASA

- [x] **Pets**/Mascotas
- [x] **Guns**/Armas
- [x] **Smoking**/Fumar
- [x] **Other**/Otros

(Habits/Habitos)

Sleep/Dormir
Naps/Siestas
Play/Jugar
Other/Otros
Snoring/Roncar
Bedwetting/ Mojar la cama

Concerns/Preocupaciones

2829 Babcock Rd Ste 438 * San Antonio, TX * 78229 * TEL. 210.692.9471 * FAX 210.692.9455

Dr. Josephine Ruiz Healy M.D.

DATE: _____
HOME PHONE: _____

PATIENT INFORMATION (Please Print)

Name of Minor/Child _____
Last Name First Name Middle Initial

Sex M ◯ F ◯ Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible: _____ **Cell Phone:** _____ **Work Phone:** _____

E-MAIL: _____

Whom may we thank for referring you? _____

Best number to contact you? _____

RESPONSIBLE PARTY AND/OR INSURANCE INFORMATION

Father's/Guardian's Name _____
Address (If different from patient's) _____
_____
Cell Phone _____ Work Phone _____
Employer _____
Soc. Sec. # _____ Birthdate _____
Do you have ins. coverage for the minor ? Y ◯ N ◯
Plan Name _____
Policy ID # _____
Group # _____
Address _____
_____
Phone # _____

Mother's/Guardian's Name _____
Address (If different from patient's) _____
_____
Cell Phone _____ Work Phone _____
Employer _____
Soc. Sec. # _____ Birthdate _____
Do you have ins. coverage for the minor? Y ◯ N ◯
Plan Name _____
Policy ID # _____
Group # _____
Address _____
_____
Phone # _____

EMERGENCY CONTACT

In an event of an emergency, whom should we contact? **(Other than parents)**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it my responsibility to inform this office of any changes in my minor/ child's medical status.

I certify that my minor/ child is covered by insurance with _____ and assign
Name of Insurance Company/ OR if Self Pay

directly to ***Dr. Ruiz-Healy*** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance,** I hereby authorize the the doctor release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. **I also acknowledge that there will be a $ 25.00 fee for appointments not cancelled within a 24 hr notice or NO SHOW, and after the 3rd I will be dismissed from the practice.**

_____ _____
Signature of Parent/Guardian **Date**

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PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Parents Name _____ Birthdate _____

Signature _____ Date _____