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

☐ **Pets**/Mascotas
☐ **Guns**/Armas
☐ **Smoking**/Fumar
☐ **Other**/Otros

(Habits/Habitos)

Sleep/Dormir _____
Naps/Siestas _____
Play/Jugar _____
Other/Otros _____

Snoring/Roncar _____
Bedwetting/ Mojar la cama _____

Concerns/Preocupaciones

4115 Medical Dr Suite 305 * 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 directly
Name of Insurance Company/ OR if Self Pay

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**

Dr. Josephine Ruiz Healy M.D.

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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.

Parent's Name _____ Birthdate _____

Signature _____ Date _____