Please read and complete the following paperwork prior to your appointment at The Block Center

Please select the appropriate history form as well. The child's form is for age birth to 18 years of age. The adult form is for over 18 years old.

The Block Center
PROVIDER NOTICE
OF INFORMATION PRACTICES

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.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact The Block Center.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $25.00(twenty five dollars) for the first twenty pages, $0.50 (50 cents) for each page thereafter, and $9.40 to mail certified with return receipt. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact The Block Center You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:
The Block Center
5913 Lovell Avenue, Suite A,
Fort Worth, TX 76107
Phone: (817) 280-9933

I hereby declare that I have received and read the copy of The Block Center's Provider Notice of Information Practices.

Patient's printed name_____

Signature of patient or parent (if minor child) _____

Date_____

The Block Center
5913 Lovell Avenue, Suite A, Fort Worth, TX 76107
817-280-9933

IT IS IMPORTANT THAT YOU OR ANYONE COMING WITH YOU NOT WEAR ANY PERFUME, COLOGNE, AFTERSHAVE OR FRAGRANCES OF ANY KIND TO THE OFFICE. THIS ALSO INCLUDES TOBACCO ODORS, SHAMPOO, HAIR SPRAY AND FABRIC SOFTENER WITH FRAGRANCE. DUE TO THE SENSITIVITIES OF DR. BLOCK AND OTHERS IN OFFICE, YOU WILL BE UNABLE TO ENTER THE OFFICE IF YOU ARE WEARING ANY FRAGRANCE. IF YOU DO COME TO THE OFFICE WITH ANY FRAGRANCE ON, ARRIVE MORE THAN 15 MINUTES LATE OR DO NOT HAVE YOUR PAPERWORK FILLED OUT COMPLETELY, YOU WILL BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT AND FORFEIT YOUR DEPOSIT.

Payment is due at the time service are rendered and is payable by cash, check, MasterCard, or Visa.

We require 24 hours notice for rescheduling appointments. If you have any questions about your appointment please call during office hours so that we may clarify them prior to your visit.

We look forward to your visit.

I understand that The Block Center does not accept insurance for payment and that I am responsible for payment of all of my medical care. I understand that payment is due at the time of service.

If you will be filing claims with your insurance company you will need to sign an authorization to release information. Many times your insurance company will request more information from our office before they will process your claim. Please fill out the attached authorization with your insurance information. Without this signed consent we will be unable to release the information and your claim will not be processed. If your insurance company requests copies of your medical records, you will be billed for the cost of making the copies and mailing them to the insurance company. The charge approved by the State of Texas for this service is $25.00 for the first 20 pages and $0.50 for each page thereafter. There will also be fees for mailing the records. These fees include a certified fee, a returned receipt fee and the postage fee. These fees vary in price depending upon how much the copies weigh and the location or 'zone' they are being mailed to. We mail all medical records certified, return receipt so that we have proof that your insurance company did in fact receive your records.

Please initial below:

_____ I agree to have the Block Center mail copies of my medical records to my insurance company and I agree to pay the fees as outlined above each time my insurance company requests copies of my medical records.

_____ I do not want The Block Center to send copies of my medical records to my insurance company.

_____ _____
Signature of Patient or Responsible Party Date

The Block Center
5913 Lovell Avenue, Suite A, Fort Worth, TX 76107
817-280-9933

PATIENT RECORD OF DISCLOSURE

In general the HIPPA privacy rule gives patients the right to request on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- □ **Home/Cell Telephone** _____
- □ **O.K. to leave message with detailed information**
- □ **Leave name/doctor with call back number only**
- □ **Work number**_____
- □ **Leave detailed message on work voice mail**
- □ **Leave name/doctor with call back number only**
- □ **When unable to contact me by phone, a written communication may be sent to my home address**
- □ **Other**_____

_____ _____
Print name of patient Birth Date

_____ _____
Signature of patient or guardian Date

Healthcare providers must keep records of PHI disclosures.

Medicaid Release Information

I,_____,
(Patient or parent/guardian of patient) understand that Dr. Mary Ann Block is not a Medicaid provider. I understand that my relationship with The Block Center is based on private pay and that I am responsible for all fees related to medical care. I understand that these fees are due at the time of service. I understand that no Medicaid claims will be or can be filed on my behalf for any services at The Block Center.

_____ _____
(Signature of patient or parent/guardian of patient) Date

New Patient Personal Information Sheet

Personal Information: Date_____

_____ _____ ____/____/_____ _____ _____ _____

Patient's Full Legal Name | Sex | Birth Date | Race | Age | Marital Status

_____ _____ _____

Patient's Social Security No. | Patient's Driver's License No. | Spouse's Name

_____

Patient's Permanent Street Address | City/State | Zip Code

_____ _____ _____

Home Phone No. | Cell Phone No. | E-Mail Address

I give permission for The Block Center to send me information and updates. I understand that if I receive emails from The Block Center that I cannot contact The Block Center through this email address. It is for information sent to me only.

_____ _____

Signature | Date

Financial Information:

_____

Responsible Party Name (First) (Middle) (Last) | Telephone No./Ext

_____ _____ _____

Social Security No. | Work No. | Driver's License No.

Please check the payment method you will be paying for your services:

( ) Cash ( ) Check ( ) Visa ( ) Master Card

Credit card number for **phone appointments** or **supplement orders**

_____Exp date_____Security Code_____

IN CASE OF EMERGENCY, NOTIFY:

_____ _____

Name | Phone Number

_____

Email address

Child's History Form
Mary Ann Block, DO, PA
5913 Lovell Avenue, Suite A, Fort Worth, TX 76107
817-280-9933

Today's Date_____

This questionnaire is to help me evaluate your child's symptoms. This history is the single most important source of information about your child. It is estimated that 70% of health problems can be solved from the history, 20% from the physical exam and 10% from lab and X-rays. If there is a question you would rather discuss personally, without your child present, mark those with an asterisk (*).

General Information

Name of child_____Date of birth_____

Address_____(City)_____(State)_____(Zip)_____

Phone(_____)_____Age_____Grade_____

Name of person completing questionnaire_____Relationship_____

1. How did you hear about The Block Center?_____
2. Name of primary care physician_____
3. Describer problems which prompted you to call The Block Center:

_____ _____

_____ _____

_____ _____

4. Have you tried other professionals for this complaint?_____If Yes, explain_____

_____

5. Has child had any treatment for this problem?_____If Yes, explain_____

_____

6. What do you wish to accomplish?_____

_____

7. Has child had all vaccines required? Yes_____No_____
8. Has child had a medical check-up in last 12 months? Yes_____No_____
9. Any current health problems? Yes_____No_____If yes, explain_____

_____

10. Has child had any psychological or educational testing? Yes_____No_____If Yes, explain_____

_____

11. List all medications and supplements child is taking_____

_____

Pregnancy and Birth History

1. Did mother have medical problems during pregnancy? Yes_____No_____

2. Was labor/delivery difficult? Yes_____No_____3. Medications during pregnancy? Yes____No____

4. Was labor induced? Yes_____No_____ 5. Was suction or forceps used? Yes_____No____

6. Length of pregnancy_____months 7. Duration of labor?_____hours

8. C-Section? Yes_____No_____ 9. Any complications during or after labor? Yes_____No_____

10. Birth weight_____pounds_____ounces 11. APGAR Scores if known_____ _____

12. Was infant born_____Head first? _____Feet first? _____Breech?

13. Did infant require any special treatment at birth? Yes_____No_____, If Yes, explain_____

_____

14. If child is adopted, age of adoption_____, Country adopted from _____

Infancy

1. Breast fed? Yes_____No_____, If Yes, how long?_____2. Breast plus formula? Yes_____No____

3. Formula only? Yes____No_____ 4. Formula changes? Yes____No___

5. Normal weight gain? Yes____No_____6. Nursing or feeding problems? Yes_____No_____

7. Age when solid food introduced_____

8. Check problems that apply to first year of life:

____ Asthma	____Congestion	____Skin Rashes	____Constipation
____Colic	____Colds	____Diarrhea	____Constipation
____Vomiting	____Excess Crying	____Diaper Rash	____Irritability
____Overactive	____Ear Infections	____Pneumonia	____Croup
____Hives	____Eczema	____Antibiotics	____Trouble Sleeping

Developmental-Approximate Age of the Following:

____Crawled_____Sat Alone ____Said Single Words ____Walked without Support

____Dressed Self ____Fed Self with Spoon ____Said Understandable Short Sentences

Problems That Apply After One Year of Age:

____Asthma ____Congestion_____Skin Rashes_____Diarrhea ____Clumsy ____Picky Eater

____Constipation_____Vomiting ____Colds ____Ear Infections_____Strep Throat_____Gas

____Pneumonia_____Aggression_____Bloating ____Loss of Language_____Sensitive to Light & Noise

____Headaches_____Nervous ____Hives ____Uncoordinated ____Trouble Sleeping

Has child had____Tonsillectomy?_____Adenoidectomy?____ Ear Tubes?_____ Age_____

Has child taken prednisone or other steroids? Yes_____No_____

Does exposure to perfumes, pesticides or other chemicals bother child? Yes____No___If Yes, what happens?

_____

Has child taken antibiotics at any time? Yes_____No_____Does child crave sweets? Yes_____No_____

Systems Review-Check All That Child Currently Has:

General

____Recent weight loss or gain (Circle which)_____Over eats ____Fatigue ____Nightmares

____Trouble Sleeping

Eyes

____Tearing ____Circles Under ____Double Vision ____Burning

____Crossed ____Squints ____Itching ____Blurred Vision

____Wears Glasses_____Has Had Eye Surgery

Ears

____Itching ____Draining ____Stopped Up ____Tubes

____Pain ____Ringing ____Infections ____Difficulty Hearing

Nose

____Congestion ____Discharge ____Picks Nose ____Sneezing

____Bleeding ____Infections ____Postnasal Drip ____Wax

Mouth/Throat

____Canker Sores ____Chapped Lips ____Bad Teeth ____Thrush

____Sore Gums ____Coated Tongue ____Fever Blisters ____Bad Breath

____Grinds Teeth ____Sore Throat ____Hoarse ____Mouth Breather

____Clears Throat ____Swollen Glands ____Thyroid Disease ____Strep Throat

Heart/Lungs

____Heart Murmur ____Cough ____Bronchitis ____Asthma

____Wheezing ____Pneumonia ____Chest Pain ____Short of Breath

____Heart Palpitations

Stomach

____Nausea ____Constipation ____Diarrhea ____Blood in Stools

____Pain ____Over Eats ____Vomiting ____Rectal Itching

____Gas ____Soiling ____Belching ____Bloating

Systems Review-Check All That Child Currently Has:

KidneyBladder

____Urgency ____Frequent Urination ____Daytime Wetting ____Nighttime Wetting

____Pain/Burning with Urination ____History of Urinary Tract Infections

Age when Dry_____Daytime _____Nighttime

Nerves/Musculoskeletal

____Headaches ____Seizures ____Dizziness ____Painful Joints

____Uncoordinated ____Tics ____Growing Pains ____Accident Prone

Skin

____Dry ____Oily ____Rashes ____Acne ____Easy Bruising

Behavior-Check All That Apply:

____Overactive ____Destructive ____Lies ____Steals ____Negative School Reports

____Unhappy ____Aggressive ____Fights ____Argues ____Talks Excessively

____Has Run Away ____Mood Swings ____Temper_____Hard to Discipline

____Disrupts Family_____Fire Setting ____Dislikes School____Sexual Inappropriateness

____Short Attention ____Doesn't Listen ____Doesn't Like Self ____Learning Problems

Amount of television by child_____hours per day;_____hours per week

Amount of time spent on computer games_____hours per day;_____hours per week

List things child does well:_____

_____

_____

List Child's greatest problems, frustrations:_____

_____

_____

List all medications child has been prescribed: _____

_____

_____

List side effects caused by medications: _____

_____

_____

Cooperation and consistency between child's parents:____Excellent____Good____Fair____Poor

How would you describe the child's school situation?____Excellent____Good____Fair____Poor

Family History

Length of current marriage_____Years Any marital problems?_____Yes_____No

Do parents agree about child's treatment?_____Yes____No Stepparent in home?_____Yes_____No

Anyone else live in house?_____Yes_____No Does anyone smoke?_____Yes_____No

Prior marriages-Mother?_____Yes_____No Father?_____Yes_____No

Birth father's Height_____Weight_____Birth mother's Height_____Weight_____

Allergy

Has child had any allergy testing?_____Yes_____No, If Yes, what type?_____Skin_____Blood

Is child taking any type of allergy treatment currently?_____Yes_____No, If yes, what?

____Prescription_____

____Over-the-counter _____

____Allergy Injections_____Avoidance

Has child been to emergency room for allergies or asthma?_____Yes_____No How often?_____

How long has child lived in area? _____

Environment

Do you live in_____House_____Apartment_____Other How long in this residence?_____

Is garage attached____Yes _____No Is there much vegetation(trees, weeds, etc.)? _____Yes _____No

Is there a lot of dust in the home?____Yes _____No Does home have basement? _____Yes _____No

Is there mold/mildew in home? Yes No Is HVAC System? Gas Electric

Any pets? _____Yes _____No What kind?_____

Are child's symptoms worse:

____Outdoors ____Indoors ____Rainy Days ____Windy Days

____Fall ____Summer ____Spring ____Winter

____At Night ____Weather Changes

Do you use?____Strong smelling cleaning chemicals ____Floor/Furniture Wax ____Pesticides

Is home regularly treated for insects?____Yes____No Do you use electric blankets?_____Yes_____No

Do you live near a power generating station/high voltage tower/transmitter?_____Yes_____No

What kind of water do you drink?_____Tap_____Filtered_____Plastic Bottled_____Glass Bottled

IMMEDIATE FAMILY

Instructions: Please include all information you know related to the following areas.
You may nee**dt** o as**k** your parents **f**or a complete historv.

					Maternal		Paternal	
	Father	Mother	Brother	Sister	Grandmother	Grandfather	Grandmother	Grandfather
Aoe if living								
Age at death								
Cause of death								
Type of worl<.								

Ma *rk* an "X" for any pos itive answer

Asthma								
Allerav Hives								
Eczema								
Hayfever								
Weight Problem								
Smokers								
Alcohol Abuse								
Mental illness								
Cancer								
Diabetes								
Hypertension								
Heart problem								
High cholesterol								
Thyroid disease								
Blood disease								
Bowel problem								
Ulcers								
Arthritis								
Migraines								
Other								

Food

Is child a picky eater?_____Yes_____No Most Meals Eaten at_____Home_____Out

Favorite Foods:

_____

Meal Times on a school day:

Breakfast_____AM Morning Snack_____AM Lunch_____AM/PM

Snack_____PM Dinner_____PM Evening Snack_____PM

Diet Diary: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Sunday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Monday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Tuesday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Wednesday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Thursday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Friday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Saturday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Mark all items:	DAILy	3 X WEEK	1-2 X WEEK	SELD0M	NEVER	CR/LA/0V/VE/E	LIKE	NEUTRIL	MCAHKI·1 ELL SDL
milk									
cheese									
oranoe juice									
apple iuice									
orape juice									
com syrup									
com meal									
popcorn									
peanut butter'									
sov products									
cram.,									
onion									
ootatos									
tomatoes									
beef									
chicken									
em:1s									
fish									
bacon									
sausaoe									
hot dogs									
sandwich meat									
bread, rolls									

Mark all items:	DAILy	3 X WEEK	1-2 X WEEK	SELDOM	NEVER	CRAVE/	LIKE	NEUTRAL	MCAHKIES LLDL
cereal									
oatmeal									
rice									
rve									
wheat									
cake cookies									
crackers									
pizza									
pasta									
suaar									
chocolate									
coffee									
coffee (decaf)									
tea									
tea (decaf)									
honev									
mushrooms									
diet soft drinks									
soft drinks									
other									