Ilianai Torres-Roca M.D.
1304 W Walnut Hill Ln. Suite 100
Irving, TX 75038
Phone: 469-941-0444

Please fill out as completely as possible and bring to the initial evaluation. Please do NOT fax, mail, or e-mail back to the clinic.

CHILD'S INFORMATION Date: ___/___/___

Child's full name:________________________ Birth Date: ___/___/___ M/F:___

PERSON ANSWERING QUESTIONS

Name:__________________________ Relationship to child: ____________________

REFERRAL INFORMATION

Referral Source:__________________ Primary Care Physician:__________________

CUSTODY AND PRIMARY CAREGIVER

Who has legal Custody of this Child?_____________________________

_____Temporary _____Permanent Telephone Number: (___)_________

Does the child have a biological parent not living with the child? ___No ___Yes

If yes; is there visitation and how frequent: ______________________________________

CHILDCARE

Who cares for the child when caregivers are working?

____

HOUSEHOLD MEMBERS (List all people living in the home)

Name	Age	(M/F)	Relationship to Child

PARENTS

Mother's Name:______________________ Location if not living with child: _______

Occupation: ____________________ Highest Grade Completed: _____________

Father's Name:______________________ Location if not living with child: _______

Occupation: ____________________ Highest Grade Completed: _____________

Family Losses (death, separation, etc.): ____ No ____ Yes, if "yes," please explain ______________

PREVIOUS PSYCHIATRIC TREATMENT

Name of Previous Provider: (Psychiatrist or Therapist)	Reason	When

Previous Hospitalizations or Residential: Location	Reason	When

PREVIOUS PSYCHIATRIC MEDICATIONS

Please list all medications, dosages, how it helped, side effects if any, and why stopped

____

____

____

____

____

Please List History of Suicidal Thoughts, Attempts, or Self-harm (cutting, burning, etc.)

____

ALCOHOL, DRUG, LEGAL & ABUSE HISTORY

Cigarettes or chewing tobacco: ____ No ___ Yes

Beer, wine, liquor: ____ No ___ Yes

Marijuana: ____ No ___ Yes

Methamphetamines or cocaine: ____ No ___ Yes

Huffing or sniffing: ____ No ___ Yes

Prescriptions (pain killers, benzo's i.e. Xanax): ____ No ___ Yes

Been Arrested: ____ No ___ Yes

Appeared in Juvenile Court: ____ No ___ Yes

Involved with Child Protective Services (CPS): ____ No ___ Yes

Involved in custody dispute: ____ No ___ Yes

Please describe any "Yes" answers

____

____

CHILD'S MEDICAL HISTORY

Please list any significant illnesses, hospitalizations or surgeries: (Include heart, head injuries, seizures, obesity, diabetes, lung, stomach, bowel, serious infections or ingestions, i.e. lead poisoning)

____

____

CURRENT MEDICATIONS	Dosage	Time Given

ALLERGIES TO MEDICATIONS AND REACTION

____

CHILD DEVELOPMENT AND EDUCATION

Duration of pregnancy: ____ Full term ____ Pre-mature Weight: ____ lbs. ____oz.

Complications during pregnancy:________________________________

Medications used during pregnancy: ________________________________

Tobacco, Alcohol, or other drug use during pregnancy:____________________

Complications during delivery: ________________________________

DEVELOPMENTAL MILESTONES (approximate age)

_____ Crawling

_____ Walking

_____ Potty trained (urine)

_____ Say 1st word

_____ Two word phrases

_____ Potty trained (bowel)

CURRENT DIFFICULTIES

____ Hearing

____ Vision

____ Feeding/Eating

____ Failure to thrive

____ Bed wetting

____ Speech delay

____ Stuttering

____ Pronunciation

____ Making friends

____ Daytime bladder/bowel

____ Excessive crying

____ Temper tantrums

____ Separation from parents

____ Cannot sleep alone

____ Sibling Relations

CHILD'S SCHOOL HISTORY

Current school and grade: ____________________ School problems: ____________________________

Has child received: ___ ECI ___ PPCD ___ Speech therapy ___ OT ___PT ___ Reading program

Retained in school: ___ No ___ Yes, what grade(s):________ 504 plan: ___ No ___ Yes

Qualified for Special education: ___ No ___ Yes, type of services: ______________________________

FAMILY HISTORY

Please list psychiatric diagnosis in family members: (depression, anxiety, ADHD, bipolar, psychosis, etc.)

Also include history of medication, psychiatric hospitalization, suicide attempts or completions

____

____

____

Please list family members with history of alcohol or drug abuse:

____

Please list significant medical history of close family: (heart disease, diabetes, seizures, etc.)

____

Please list history of legal, incarceration or violent behavior in family members:

____

_______________________________ _______________________________

Parent Signature

Physician Signature / Date

Ilianai Torres-Roca, M.D., P.A.

1304 W Walnut Hill Ln, Suite 100
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(469) 941-0444

Section I: Patient Information Date ____________

Name: ______________________ Date of Birth ____________ Age: ________

Address: ______________________ City: ____________ State: ________ Zip: ________

Phone: ______________________ Email: ______________________ By applying email you are giving consent to email you.

Check Appropriate Box: Minor Single Married Widowed Separated Divorced

If parents are divorce or if applicable please provide custody/guardianship documents.

If Minor: Please provide Mother and Father's (or legal guardian's) Information

Mother: ______________________ Phone: ______________________ DOB: ________

Father: ______________________ Phone: ______________________ DOB: ________

Referral Source: ______________________

Is it okay if we contact you and leave messages at the above emails and phone numbers? If it is please sign the line below. If it is not, please let the receptionist know.

____

Name: ______________________ Relationship to Patient: ______________________

Section II: Responsible Party Relationship to Patient: Self Spouse Parent Other

Name: ______________________ DOB: ______________________

Address ____

City: ______________________ State: ____________ Zip: ________

Phone: ______________________ Cell Phone: ______________________

Employer: ______________________

Part III: Insurance Information

Name Primary Insured: ______________________ DOB: ________ Relation to Patient: ____________

Insurance Company Name: ______________________ Phone Number: ______________________

Member ID: ______________________ Group#: ______________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, ASK THE RECEPTIONIST FOR AN ADDITIONAL FORM.

Notice of Privacy Practices for Ilianai Torres-Roca, M.D.

To our patients: this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information is certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request

that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Torres-Roca.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Torres-Roca. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office at 469-941-0444. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office at 469-941-0444.

I,________________________________authorize Dr Torres-Roca's office to release information to the following individuals.

Name:__________________________Relationship:______________Phone:_______________

Name:__________________________Relationship:______________Phone:_______________

I hereby acknowledge that I have been presented with a copy of Dr Torres-Roca's Notice of Privacy Practices.

Signature:____

Date:____

Name of patient:____________________________________

ILIANAI TORRES-ROCA, MD, PA
1304 W Walnut Hill Ln., Suite 100
Irving, TX 75038
PH: 469-941-0444 FAX: 469-209-6075

Office Policies

-If you are unable to keep your appointment please cancel with at least 2 business day advance notice.

-If you do not cancel your appointment with at least 2 business day advance notice, you will be charged a $75no-show/late cancellation fee. You will not be able to schedule an appointment until that fee is paid.

-There is a $50-75 charge on any disability/FMLA paperwork/letter completed by Dr. Torres-Roca. Expect to wait at least three to five business days for it. If you want us to mail it or fax it to anyone else but yourself, please make sure you sign a release of information and bring an addressed stamped envelope.

-Please note that it is the patient's or guarantor's responsibility to pay any portion of the bill not covered by insurance.

-After 3 missed appointment, we will no longer provide services unless all missed appointments are paid in full either with cash, money order or cashier's check.

-Please notify our office of any insurance changes at least 2 days prior to your appointment.

______________________________ ______________________
Patient's Name Date of Birth

______________________________ ______________________
Legal Guardian's Name (If applicable) and/or Guarantor's Relationship to patient

______________________________ ______________________
Signature Date