MARYLAND PEDIATRICS REGISTRATION FORM

PATIENT INFORMATION

First Name | Middle | Last Name | Nickname

Date of Birth | Male | Female

Home Phone Number | Work Phone number | Cell Phone

Address | City | State | Zip Code

Emergency contact | Relationship to patient | Phone Number

INSURANCE INFORMATION

Primary Insurance Company Name | Policy Number | Group/Plan Number

Insured's Name | Insured's Date of Birth | Relationship to Patient

Secondary Insurance Company Name | Policy Number | Group/Plan Number

Insured's Name | Insured' Date of Birth | Relationship to patient

PARENTS/GUARDIAN INFORMATION

Mother's Information		**Father's Information**	
Name		Name	
Mother's SS #	DOB	Father's SS #	DOB
Address		Address	
E-mail Address		**E- mail Address**	
Home Phone Number	Cell Phone Number	Home Phone Number	Cell Phone Number
Employer Name	Phone Number	Employer Name	Phone Number
Are there any legal restrictions regarding custody? NO or YES If yes, please explain.			

SIBILINGS INFORMATION

Name	DOB	Insurance Name : ID Number:
Name	DOB	Insurance Name: ID Number:
Name	DOB	Insurance Name: ID Number:
Name	DOB	Insurance Name: ID Number:

CMS required

Language other than English			
Ethnicity	O Unknown O Not Hispanic or Latino	O Hispanic or Latino O Decline	
Race	O American Indian or Alaskan Native O Asian O African – American or Black O Hawaiian Native or Pacific Islander O White O Decline		
How would you like to be contacted (mark one) Medical Issues Appointments and other Reminders Come Back to Office Recalls Billing Status General Notice Patient Portal	Home Phone,	Cell Phone,	Work Phone,
	e-mail only e-mail only		

Privacy and Billing

I authorize the release of any off my children's medical information needed to process insurance claims and payments. I have been offered a copy of The Notice of Privacy Practice HIPPA.

I fully understand that I am financially responsible for all charges and balances remaining from claims as well as charges denied or not covered by my insurance.

Signature_____Date_____

MARYLAND PEDIATRICS

Notice of Privacy Practice

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

Your Rights

When it comes to your health information, you have certain rights.

Your Choices

For certain health information, you can tell us your choices about what we share.

Our Uses and Disclosures

How do we typically use or share your health information?

Our Responsibilities

We will not use or share your information other than as described here unless you tell us we can in writing.

I understand that patient's health information is private and confidential. I understand that Maryland Pediatrics works very hard to protect patient's privacy and preserve the confidentiality of the patient's personal health information. Maryland Pediatrics Notice of Privacy Practices contains a complete description of my privacy/confidentiality rights. I understand Maryland Pediatrics reserves the rights to change the terms of this Notice of Privacy Practices.

Please click the link for a complete copy of Maryland Pediatrics Notice of Privacy Practice.
Maryland Pediatrics NPP

For a hard copy please ask our front desk.

I have been offered and read a full copy of Maryland Pediatrics Notice of Privacy Practice

Patient's Name: _____DOB_____

Parent or Guardian: _____

Signature: _____Date:_____

REV 1/1/2023
Privacy Officer; Office Manager, Maryland Pediatrics

Maryland Healthy Kids Program

Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Today's Date	Relationship:

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____

Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe:
Type of delivery? ☐ Vaginal ☐ C-section

Birth Weight _____ Discharge Weight _____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization: _____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household? _____

How many? _____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child? _____
Date of Birth? Mother _____
Father _____

Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____ Dates: _____
Other Languages _____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Chicken Pox (Year) _____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐

Current Medication(s): (*List*) _____

Reviewed by:	Date of Review:

OFFICE POLICY

Letting you know in advance of our office policy allows for a good flow of communication and enables us to better serve you. Please read this carefully. If you have any questions, please do not hesitate to ask a member of our staff.

Calling for Appointments:
We offer same day sick appointment for our patients
Well checkups or Physical exams, Sport Physicals, Med – checks; please call ahead of time to make any of these appointments, this will assure you, time and day most convenient for you.

Cancelling Appointments:
If you must cancel your appointment, please call 24 hours or more prior to your appointment so we can open our schedule to assist other patients. There is a fee for cancelling appoints less than 24 hours prior to your appointment.

Not Showing to your Appointment:
Missing an appointment prevents us from seeing other patients in need of our service. It is our office policy to charge a fee for no show. After 3 no shows our office may contact you to let you know you need to transfer to another practice.

After Office Hours:
If you have an emergency please call 911.
There is always a doctor on call. Call our office main number 410 442-4011, the answering service will put you in contact with the doctor on call.

Health Insurance:
We accept most private and state health insurance.

We submit all medical claims on your behalf to your insurance plans.

According to your insurance plan, you are responsible for any and all co-payments, deductibles, and services not covered by your insurance. Co-payments are due at time of service. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
A fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INACTIVE OR INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.

If we are your primary care physician, make sure our name and/or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.

YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.

If you have no insurance, payment for an office visit is to be paid at the time of the visit.

If our providers do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.

Transferring Medical Records:
We charge a state regulated fee per child to copy or transfer medical records.

Forms:
If your child has school, camp, or sport forms to be completed, there is a **fee** charge per form. Payment is due when the forms are dropped off. We have a 5- to 7-day turnaround time for forms. If a form is needed sooner, you may request *rush* service for and additional fee.

Prescription Refills:
For monthly medication refills, we require 48 hours' notice, please plan accordingly. All prescriptions are send electronically to the pharmacy of your choice.
For control substances prescriptions; parents must pick up prescriptions at our office and your child must have a med-check exam within the last 4 month in some cases 3 month depending on medication side effects.

Referrals:
We require that referrals be requested at least 3 days prior to your specialist appointment. Referrals need to be approved by our doctor. When calling our office, please have ready doctors name and phone number as well as appointment day and time.

I have read and understand this office policies and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

_____ _____
Responsible party member's name Relationship

_____ _____
Responsible party member's signature Date