Takoma Park Pediatrics

7610 Carroll Avenue Ste#400 Takoma Park, MD 20912 **2010 Patient Registration**

Please complete entire registration

Last Name First MI

Address **APT#** Zip City State

Phone# DOB Age: Male/Female (Child's) SS#

Mother's Name Mom's DOB SS#

Mother's Employer Work Phone# **Cell Phone#**

Father's Name Dad's DOB SS#

Father's Employer Work Phone# **Cell Phone#**

Father's Address (If different from above)

Emergency Contact Relationship to Pt Phone#

Name of Person Financially Responsible other than Insurance:

Address/Phone of Person

1. PRIMARY INSURANCE

Insurance Company Policy# Group#

Insurance Address Phone#

Subscriber Name *Employer* *DOB* *SSN#*

2. SECONDARY INSURANCE (If any)

Insurance Company Policy# Group#

Insurance Address Phone#

Subscriber Name *Employer* *DOB* *SSN#*

3. **Does your child also have medicaid/medical assistance?** Yes / No Recipient ID:

Siblings of this child at this practice:

1. ____________________ Date of Birth: ____________
2. ____________________ Date of Birth: ____________

List two people that may be authorized to bring the patient in the office and discuss care with the physician.

1. ____________________ Relationship to Patient ____________
2. ____________________ Relationship to Patient ____________

I hereby consent to the use and disclosure of my child's Private Health Information (PHI) and Individually Identifiable Health Information (IIHI) for payment, treatment and other healthcare operations, according to the Health Insurance Portability and Accountability Act of 1996, effective April 14, 2003. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY HEALTH INSURANCE AND AGREE TO PAY THE BALANCE OWED BY ME.

Parent/Guardian Name Print: ____________________ Date:

Parent/Guardian Signature For This Authorization: ____________________

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:

	No	Yes	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:

	No	Yes
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:

Maryland
Vaccines for Children (VFC) Program

Patient Eligibility Screening Record

The provider is **not** required to verify responses by the parent, guardian, or individual of record.

Date: ____

Child: ____

Last Name First Name MI

Date of Birth: ____

Parent/Guardian/
Individual of Record:____

Last Name First Name MI

Health Care Provider: ____

The provider's office must keep this form for each child (birth through 18 years of age) who receives immunizations through the Vaccines for Children (VFC) Program in Maryland in the patient's permanent medical record for six years. The health care provider or the parent, guardian, or individual of record may complete this form, and should complete a new form if the child's status changes. The provider may use this record for all subsequent visits as long as there is no change in the child's eligibility status.

This child qualifies for vaccination through the Maryland VFC Program because he/she (please check only one box):

(a) Is covered by or enrolled in Medical Assistance ☐ **or**

(b) does not have health insurance ☐ **or**

(c) is Native American (American Indian) or Alaskan Native ☐ **or**

(d) has health insurance that does not cover (pay for) vaccines ☐