PLEASE CHECK ONE:

- ☐ James Kopper, M.D.
- ☐ Michele McEwan, M.D.
- ☐ Dianne J. Landrum, M.D.
- ☐ Christine M. Reilly, M.D.
- ☐ Rumneet Saini, M.D.
- ☐ Monique Burke, M.D.
- ☐ Henry Chang, M.D.
- ☐ Bethany Fry, FNP-BC
- ☐ Elizabeth Johnson, CRNP
- ☐ Emily Spears, CRNP
- ☐ Rebecca J. Chamberlain, CPNP

CHART # ____________________

The Pediatric Center, L.L.C.

5900 Waterloo Road • Suite 110 • Columbia, MD 21045

(443) 451-1600 • Fax (443) 451-1619

PATIENT'S AUTHORIZATION

I hereby authorize The Pediatric Center to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physicians of The Pediatric Center and hereby direct my insurance carrier intermediaries to issue payment DIRECTLY to THE PEDIATRIC CENTER on behalf of such rendered services. I understand that I am financially responsible to this office for any balance not covered by my insurance carrier after 45 days. A copy of this is as valid as the original.

Signature of Responsible Party ____________________ Email of Responsible Party ____________________ Date ____________________

Parent Name: ____________________ D.O.B. __________ S.S. # __________

Address ____________________ Zip Code __________ Home Phone __________

Employer Name ____________________ Work Phone __________

Employer Address ____________________ Cell Phone __________

Parent Name: ____________________ D.O.B. __________ S.S. # __________

Address ____________________ Zip Code __________ Home Phone __________

Employer Name ____________________ Work Phone __________

Employer Address ____________________ Cell Phone __________

Child/Children reside at the following address ____________________

PRIMARY INSURANCE: ____________________

Address ____________________ City __________ State/Zip Code __________

Insurance Policy Holder ____________________ D.O.B. __________ S.S. # __________

Address ____________________ Home Phone __________

ID # ____________________ Group # __________ Copay __________

SECONDARY INSURANCE: ____________________

Address ____________________ City __________ State/Zip Code __________

Insurance Policy Holder ____________________ D.O.B. __________ S.S. # __________

Address ____________________ Home Phone __________

ID # ____________________ Group # __________ Copay __________

Please list all children who are or will be patients of The Pediatric Center, including the child being seen today.

	Name	Birth Date	Sex	Allergy
1.				
2.				
3.				
4.				
5.				

EMERGENCY CONTACT:

Name ____________________ Relationship __________

Address ____________________ Home Phone __________ Cell Phone __________

Date: ____________
Informant: ____________
CH. No. ____________

PEDIATRIC HEALTH HISTORY

PATIENT NAME: ______________________ DATE OF BIRTH: ____________
ADDRESS: ______________________ TELEPHONE NO.: ____________
____

SECTION 1. FAMILY HISTORY:

1. Current family members:

	Name	Age	Illness or Deceased (age)
Mother			
Father			
Sister(s)			
Brother(s)			
Other(s) Relationship:			

SECTION 2. SOCIAL HISTORY

1. Does anyone in current family smoke cigarettes? _______No _______Yes

2. Has anyone in child's biological or natural family (parents, siblings, or grandparents) had: (Check if Yes)

Bleeding Disorder____
Tuberculosis ____
Kidney Stones ____
Diabetes ____
Cancer ____

Asthma/Allergy (particular to medicines) ____
Heart Attack or Heart Disease ____
Seizures or Epilepsy ____
Anyone in family die before age 40? ____

3. Does anyone other than parent take care of the child regularly?
______ No ______ Yes Who? ______________________

4. Does child attend school (or daycare) regularly? ______ No ______ Yes
NAME OF SCHOOL: ______________________ GRADE: ________
Regular class ____ Special class ____
Grade Failures ____ No ____ Yes Which grade(s): ____________

5. Home situation: Who shares your home with you and the patient?
____

6. Is this child adopted? _______No _______Yes

SECTION 3. PAST MEDICAL HISTORY

1. During pregnancy with this patient, did patient's mother experience: (Check if Yes)

Toxemia or Pre-eclampsia _____
Vaginal Bleeding _____
Alcohol Intake _____
Smoking _____

Take any prescriptions _____
Take any drugs _____
Marijuana use _____
Fever _____

NOTICE OF PRIVACY ACT

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.

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this office notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sides and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on this posted copy.

EFFECTIVE: June 1, 2003
Privacy Officer: Office Manager, The Pediatric Center, LLC

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

PATIENT NAME: ______________________________ DATE OF BIRTH: ________________

I have received this practice's Notice of Privacy Practice written in plain language. The Notice provides in detail uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand and have obtained this practice's current Notice of Privacy Practices.

SIGNATURE: ______________________________ DATE: ________________________

Relationship to Patient (if signed by a personal representative of patient) ________________________