

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:

	<u>Name</u>	<u>Age</u>	<u>Illness or Deceased (age)</u>
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 _____ | Asthma/Allergy (particular to medicines) _____ |
| Tuberculosis _____ | Heart Attack or Heart Disease _____ |
| Kidney Stones _____ | Seizures or Epilepsy _____ |
| Diabetes _____ | Anyone in family die before age 40? _____ |
| Cancer _____ | |

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 _____ | Take any prescriptions _____ |
| Vaginal Bleeding _____ | Take any drugs _____ |
| Alcohol Intake _____ | Marijuana use _____ |
| Smoking _____ | Fever _____ |

2. What type of delivery? _____ vaginal _____ C-section
3. What birthweight? _____ lbs. _____ oz.
4. Did delivery occur: _____ at/before 37 weeks (If Yes, do you know why? _____
 _____ 38-42 weeks
 _____ Later than 42 weeks

5. Were there any complications at birth? _____ No _____ Yes

6. Was the baby yellow in color? (Yellow-Jaundice) _____ No _____ Yes
 How many days old was the baby when he/she went home? _____

7. Were there any difficulties after birth? _____ No _____ Yes
 Did the baby need oxygen? _____ No _____ Yes
 Was the baby blue in color? _____ No _____ Yes

8. Has the child ever been hospitalized overnight or had any operations? _____ No _____ Yes
 If yes, please list each admission:

Hospital	Dates	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Does patient have: (Check if Yes)

Asthma _____	Hay Fever _____
Food Allergy _____	Bee Sting Allergy _____
Penicillin Allergy _____	Any Other Allergy _____

10. Has patient ever had: (Check if Yes)

Hepatitis (Yellow Jaundice) _____	Scarlet Fever _____
Measles _____	German Measles _____
Chicken Pox _____	Mumps _____
Ear Infections _____	Strep Throat _____
VD _____	

11. List any other serious illness or injuries that the patient has had:

12. List all medications which this child uses regularly or has used regularly in the past:



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) _____