PATIENT REGISTRATION FORM

☐ New Patient
☐ Info-Update

☐ Work Related Injury
☐ Auto-Accident Related

Date Completed _____
Employee Initial _____

PATIENT INFORMATION

Name: (First, MI, Last)	Sex	Home Phone:	
Address: (Street#)		Social Security #:	
City, State	Zip	DOB	Marital Status
Employer	Job Title	Work phone #:	Cell phone #:
Name and phone number of emergency contact			

REFERRING PHYSICIAN INFORMATION

Referred by:	Office Phone #:
Address	
Primary care or family physician name	Office Phone#;
Adress	

FINANCIAL RESPONSIBILITY

Name of person financially responsible: (if patient is a minor)		Relationship to Patient:
Address: (Street#, City, State, Zip) ** If different than patient**		
Phone #	DOB	Social Security #

INSURANCE INFORMATION

Primary Insurance carrier	Group #	ID #	
Policy Holder's Name (First, MI, last)	PCP Co-pay amount	Specialist Co-pay amount	
Address: (Street#, City, State, Zip) ** If different than patient**			
Phone #	Relationship	DOB	Sex
Employer	Social Security#	Effective date of insurance	
Secondary Insurance carrier	Group #	ID #	
Policy Holder's Name		Relationship to patient	

_____ Patient Signature

_____ Date

Revised 8/05

Welcome to V Care Pediatrics

11200 Scaggsville Road #120 Laurel, MD 20723

Phone: (240) 360-5992 Fax: (855) 371-0566

New Patient Information and Medical History

Child's Full Name _____ Date of Birth _____

Previous Doctor(s) _____ Phone # _____

Address _____

How did you hear about us? _____

Mother's Name _____

Mother's Occupation _____

Does mother live with child? [ ] Yes [ ] No

Father's Name _____

Father's Occupation _____

Does father live with child? [ ] Yes [ ] No

Legal Guardian Name _____

Is the child adopted? [ ] Yes [ ] No

Is the child in foster care? [ ] Yes [ ] No

Names of siblings/Birthdates _____ __/__/__

_____ __/__/__

_____ __/__/__

_____ __/__/__

Mother's age at birth _____

Birth weight _____lbs _____oz

Was baby born early? [ ] Yes [ ] No

Type of delivery [ ] Vaginal [ ] C-section

Number of days baby stayed in hospital after birth _____

Check if mother had any of the following during pregnancy or delivery:

[ ]Infections [ ]Diabetes [ ]Drug/alcohol use [ ]Cigarette use [ ]Early labor [ ]Other complication

Medical History

	Yes	No	Explain (include dates if known)
Does your child have any chronic conditions or diseases?			
Hospitalizations?			
Surgeries?			
Emergency room visits?			
Food allergies?			
Medication allergies?			
Immunization reactions?			

Check if your child has ever had any of the following:

- ☐ Chickenpox
- ☐ Frequent ear infections (>5/yr)
- ☐ Urinary tract infection
- ☐ Frequent headaches
- ☐ Heart murmur
- ☐ Seizures/Epilepsy
- ☐ Anemia/low blood count
- ☐ Loud snoring
- ☐ Pneumonia
- ☐ Depression/ emotional problem
- ☐ RSV/Bronchiolitis
- ☐ Eating disorder/Anorexia
- ☐ Stomach problems/reflux
- ☐ Poor school performance
- ☐ Other:

Please list any health concerns you have _____

_____

_____

Please list any medications your child is currently taking _____

_____

Do you have any concerns about your child's development or behavior? [ ] Yes [ ] No [ ] Not sure

Family History

Check if a family member *other than the child* has ever had any of the following – WHO?

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart disease before age 55
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Sudden death from unknown cause
- ☐ Complications from anesthesia
- ☐ Schizophrenia
- ☐ Depression
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Tuberculosis (TB)
- ☐ Sickle cell disease

Authorization for Release of Information

Patient Information: Print Name: _____ Date of Birth: _____

Please release my healthcare information from:

Name of Facility/Provider: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____

Fax Number: _____

Please send my healthcare information to:

Name of designated recipient:

V Care Pediatrics

Address: **11200 Scaggsville Rd, ste 120**

City/State/Zip Code: **Laurel MD 20703**

Phone Number: **240-360-5992**

Fax: **855-371-0566**

Information to be released

_____The most recent 2 years- of pertinent information (chart notes, labs, ultrasounds and special tests)

_____All medical records (please note we are not authorized to give you medical records that we received from outside sources)

_____Vaccination record, recent complete physical exam and growth chart

Purpose for which disclosure is being made

____Sharing with other health care providers

____Legal Investigation

____I am transferring my care to another provider:

____Reason for transferring care:

_____Personal use

____Other:

Patient Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). Pediatric Place is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (payment, treatment or enrollment. I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to patients available at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time I may no longer be protected under Privacy laws.

Fees for Copying Medical Records

Our charges to release records to a patient or relative are as follows: $.83 cents per photocopied page for paper records, $.62 for electronic records. In addition, the actual cost of shipping and handling charges will apply. This fee must be paid before your records can be released.

I understand the I may be charged at the rates shown above for the copies of the records I have requested and for the postage, I agree to pay the total charges upon receipt of the copies.

Signature: _____ Date_____

*Please provide documents to prove authority to sign on behalf of patient

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED

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11200 Scaggsville Road #120 Laurel, MD 20723
Phone: (240) 360-5992 Fax: (856) 371-0666

Patient Authorization for Communication of Protected Health Information

Patient Name (print) _____ Date of Birth _____

It is frequently necessary for personnel at this practice to communicate lab results, instructions and or information about treatment, payment, and other items of protected health information with our patients. It is frequently not possible to speak directly with our patients' guardians to leave this information. In the event that our personnel are not able to speak with you personally, please give us instructions about communicating with you.

Pharmacy Preference: _____ Pharmacy Location: _____

1. Messages may be left on my home answering device @ the following number:

2. My home answering device does not identify me by name however, it is acceptable to leave messages for me. (circle) yes no

3. Messages may be left for me on my voicemail at my employer's. @ _____

4. Messages may be left for me on my cell phone voicemail @ _____

5. Messages may be texted to me on my cell phone @ _____

6. Messages may be left for me with my spouse or significant other (name) _____

7. Messages may be communicated to me via email @ _____

8. Other person(s) authorized to receive messages on my behalf: _____

A) Name: _____

B) Name: _____

9. Other person(s) authorized to decide upon and consent to rendering of any medical diagnosis and treatment, including surgery, which he/she deems in the best interest of the health and welfare of our child.

A) Name: _____ B) Name: _____

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This consent is valid for one year from the date of signature unless otherwise revoked in writing.

Signature of Patient or Patient/Guardian Relationship Date

Please be advised if any of our physician's/providers are asked to be involved in any legal matter requiring our participation pertaining to you or your child via telephone, court deposition and or court appearance we will charge you a fee for these services. This will include preparation time, professional time and transportation costs. The parent whose attorney is requesting the information will be the parent billed if the parents are not living together. The fee will be three hundred dollars per hour. The fee will be an out of pocket expense as we will not bill your insurance carrier.

I understand that I am responsible for any legal fees that may occur as stated above.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPP A"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

V Care Pediatrics

"We Care"

How did you hear about us?

- ☐ Google Search
- ☐ Google Maps
- ☐ Bing
- ☐ Facebook
- ☐ Patient Referral
  Who: _____
- ☐ Marketing events
- ☐ WIC Office
- ☐ Ob/Gyn: _____
- ☐ Other: _____