PATIENT REGISTRATION: 0 – 12 YEARS OLD

Partners in Pediatrics & FAMILY HEALTH

"no such thing as a dumb question"

303 Memorial Blvd. W. ▪ Hagerstown, MD 21740
Phone 301-791-7060 ▪ Fax 301-791-8990

READ: Please fill out all information requested below honestly. Do not leave out any part. Any dishonesty jeopardizes your health, your child's health, and the doctor - patient relationship. It is the patient's responsibility to update any changes in disclosed information. Any failure to disclose requested information in a timely manner OR dishonesty or deceitfully by any patient/responsible party will result in discharge from the practice.

*Today's Date: _____

* Patient Name: _____ *DOB: _____

Sex: __ Female __ Male SSN: ____ Birth Hospital: _____

***Home Address: _____**

***Mailing Address: _____**

***P O Box: _____ *Cell Phone#: _____ Other Phone #: _____**

***Email Address: _____**

Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino ___ Decline to specify

Race: ___ American Indian ___ Asian ___ Black/African American

___ Pacific Islander ___ White __ Decline to specify.

How did you hear about us: _____

_____

GUARDIAN/RESPONSIBLE PARTY

Primary Guardian's Name: _____ Relationship: _____

*Cell Phone#: _____ Other Phone #: _____

Email: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

*Cell Phone #: _____ Other Phone #: _____

Patient's Name: _____ DOB: _____

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COARDINATION OF CARE

Preferred Pharmacy Name: _____Location: _____

Dentists Office: _____ Date of Last Visit: _____

Known Allergies: _____

AUTHORIZED RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Partners In Pediatrics and Family Health to release my medical information to the following people listed below.

Without giving consent, no HIPAA protected information can be provided to anyone, regardless of their relationship to the patient. You are giving consent to these members of your care team (e.g., Doctor, therapist):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Cell Phone #: _____ Cell Phone #: _____

Other Phone #: _____ Other Phone #: _____

PRIMARY INSURANCE (This section must be filled out)

* Insurance Company Name: _____ Member ID#: _____

Group #: _____ PCP (If applicable): _____

Co-Pay: $_____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Patient: _____

Insurance Provider Phone Number: _____

Patient's Name: _____ DOB: _____

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SECONDARY INSURANCE

Insurance Company Name: _____ Member ID#: _____

Group #: _____ PCP (If applicable): _____

Co-Pay: $_____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Patient: _____

Insurance Provider Phone Number: _____

TERTIARY INSURANCE

Insurance Company Name: _____ Member ID#: _____

Group #: _____ PCP (If applicable): _____

Co-Pay: $_____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Patient: _____

Insurance Provider Phone Number: _____

OFFICE POLICIES

PLEASE INITIAL BELOW:

- Photo ID and valid insurance cards must be presented at each visit. _____
- It is the patient's responsibility to know the terms of their insurance. _____
- Appointment cancellations required 24 hours notice, otherwise a $25 missed appointment fee will be administered. _____
- All account balances, co-pays, coinsurance and deductibles must be paid/cleared before the patient is checked-in for the day's appointment. _____
- Our time is extremely valuable to other patients. We observe the 3-strike policy. Persistent cancellations or No-Show of appointments will result in the patient being placed on the discharge list and subsequently discharged from the practice. _____

Patient's Name: _____ DOB: _____

PATIENT REGISTRATION: 0 – 12 YEARS OLD

OFFICE POLICIES (CONTD.)

PLEASE INITIAL BELOW:

- Being more than 10 minutes late may require the appointment to be rescheduled. _____
- Medical records request, school forms, immunization records, FMLA, Worker's comp paperwork and any other paperwork requests require 5-6 business days for such requested document to be prepared and ready to be picked. _____
- Some records and paperwork, including medical records and letters from our provider, require a preparation fee. See our service fees list. _____
- All patients are required to behave in a professional, respectful and responsible manner. Parents/Guardians must control their children/wards. Our office is a professional environment, no cursing, foul language (the "F", "N", "B" etc. words) or adult temper tantrums are allowed. _____
- Partners In Pediatrics and Family Health operates a drug free, nonsmoking/vaping campus. Please do not bring any drugs, cigarettes/e-cigarettes/vape pens/cigars, or other nicotine/marijuana delivery systems onto our property. _____ _____
- Throw your trash, including used face masks candy/snack/food wrappers, used diapers, and such, into the trash bins. Do not leave any mess in our restrooms, examination rooms or anywhere else on our property. Use the trash bins. Respect our Property. _____
- No part of the property of Partners In Pediatrics and Family health is a playground. Stay out and keep your children/wards out of the decorative stones/pebbles around our office. Your insurance does not pay for the upkeep of the property. _____
- Failure to comply with any of our office's policies may result in the patient being discharged from our Practice. _____

NOTICE OF PRIVACY PRACTICE

A paper/electronic copy of the notice of privacy practice has been offered to me.

I accept _____, or decline _____ my paper copy, having been notified that a master copy is always on file at the office for my review at any requested time (also available in Spanish).

Patient/Guardian's signature (for Minors): _____ Date: _____

Patient's Name: _____ DOB: _____

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ASSIGNMENT OF BENEFITS/PERMISSION TO TREATMENT

I certify that this registration information is true and accurate. I certify that this medical information is, to the best of my knowledge, accurate. I authorize partners In Pediatrics and Family Health to treat my child/ward, listed above as the patient.

I authorize Partners In Pediatrics and Family Health to bill my medical insurance for services rendered on my behalf.
I authorize payment of health insurance benefits directly to DEJ Med Practice, LLC dba Partners In Pediatrics and Family Health under the terms of my Insurance.

I understand failure to provide valid insurance information at anytime will result in full financial responsibility on my part. I understand that I am responsible for all co-pays, deductibles and
coinsurance amounts as per my contract with my insurance company.

Guardian's Name (Print): _____ Date: _____

Guardian's Signature: _____ Date: _____

Social History

Home Life

Lives with both biological parents? _____ Split custody between parents? _____

Sole custody of one parent? _____. Sole custody of a guardian? _____

Foster guardian(s)? _____. Adoptive guardian(s)? _____

Number of Siblings: _____

Do animals live in the home? Yes: _____ No: _____

Any smoking inside the home? Yes: _____ No: _____

Any guns present in the home? Yes: _____ No: _____

Has patient ever smoked? Yes: _____ No: _____

Has patient ever drank alcohol? Yes: _____ No: _____

Has patient ever used recreational drugs? Yes: _____ No: _____

Has patient experienced Physical or Sexual abuse? Yes: ____ No: ____

Patient's Name: _____ DOB: _____

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Daycare/Childcare

In home daycare_____ Preschool/Facility: _____ Relative: _____

Home with Parent/Guardian: _____

Daily Routine

Brushes teeth daily? Yes: _____ No: _____

If No, Why not: _____

Home water is fluoridated? Yes: _____ No: _____

Seat belts used each time during transportation? Yes: _____ No: _____

If No, Why not: _____

Smoke detectors in home? Yes: _____ No: _____ If No, Why not: _____

Daily vitamins? Yes: _____ No: _____ If Yes, Liquid: __ Chewable: __ Swallowed whole: __

PATIENT MEDICAL HISTORY

PRINT YES OR NO TO THE FOLLOWING QUESTIONS. Does your child have or has had any of the following?

ADD: ____	**ADHD: ____**	**Allergies: ____**	**Anemia: ____**
Autism: ____	**Constipation: ____**	**Asthma: ____**	**Diabetes: ____**
Depression: ____	**Frequent Sore throat: ___**	**Diarrhea: ____**	**Reflux: ___**
Eczema: ___	**Hearing Loss: ____**	**Heart Disease____**	**Pneumonia: ____**
Rash: ____	**Urinary problems: ___**	**Cancer: ___**	**Seizure: ____**
Bed wetting: ____	**Ear Infections: ____**	**If yes, how often: _____**	**Chicken Pox: ____**

Other____ **Please list any hospital stay and/or surgeries_____**

_____

OFFICE USE ONLY

Patient's Name: _____ DOB: _____

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FAMILY HISTORY

Please check any that apply to blood relatives of the patient and list their relationship to the patient.

(Mother, father, maternal grandmother/grandfather, paternal grandmother/grandfather, paternal aunt, paternal uncle, etc.)

DISEASE	RELATIONSHIP TO PATIENT	DISEASE	RELATIONSHIP TO PATIENT
HIV/AIDS		Alcoholism	
Allergies		Anemia	
Arthritis		Asthma	
Genetic Disorders		Depression	
Mental Illness		Cancer	
Diabetes		Drug Abuse	
GI Disease		Hearing Loss	
Heart Disease		High Blood Pressure	
High Cholesterol		Kidney Disease	
Liver Disease		Migraines	
Seizures		SIDS	
Stroke		Thyroid Disease	
Tuberculosis		Multiple Sclerosis	
Obesity		Sleep Disorder	
Epilepsy		COPD	
Alzheimer's Disease		Physical Abuse	
Sexual Abuse			

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Authorization for Release of Patient Identifiable Health Information

Date of Request: _____

I, _____ hereby authorize Partners in Pediatrics and Family Health

_____ To release to **_____To obtain from**

_____

Name of Physician, Hospital, Insurance Company, Self, Etc.

_____

Address, P.O.BOX, City, State, Zip Code

The following information will be released from the Medical Records of:

_____ _____ _____

Patient Name D.O. B Social Security number

Specific Information to be disclosed: ____ Entire Medical Records ____ Immunization Records

____ Other

***This health information is needed for: ___ School ___ Personal Use ___ Continuing Medical Care**

___ Leaving the Practice ___ Legal Reasons ___ Military ___ Soc. Security Disability ___ Other

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immuno-deficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease. I authorize the disclosure of specific information.
- I also understand that the person giving authorization by written and dated notice to the Medical Record Department may revoke this authorization.
- I understand that this revocation will not apply to information that has already been released in response to this authorization.
- I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it,
- I understand I may be charged for copies of my healthcare information.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
- I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this to ensure healthcare treatment.

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature (for Minors) _____ Date: _____

There is a $30 charge for a copy of each complete medical record for those transferring from this office.
This document is **valid for only one year** from the date of signature.

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General Consent/Authorization Form

***Year: _____**

Please answer **all Questions **honestly**; your answers will be kept confidential. If you are dishonest in your answers, you will be discharged as a patient from our practice.*

***Today's Date: _____* Current Cell Phone#: _____**
***Patients Name: _____ *Date of Birth: _____ *Email Address: _____**
Please read carefully:

- All charges (co-pay, deductibles, self-pay, etc) are **due at the time professional services are rendered**.
- For those services provided and submitted to my insurance company, I hereby authorize the payment of medical benefits to Partners In Pediatrics and Family Health, here in after known as PIPFH (DEJ Med Practice LLC.)
- The patient is responsible for all fees.
- The fee ticket may be used to file insurance claims.
- For minors: I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by PIPFH.
- I hereby authorize PIPFH to furnish information to any insurance company or authorized agency Specified, regarding information concerning my medical care.

Consent for Treatment: I authorize providers at PIPFH to perform examinations, procedures, laboratory tests and to administer such medication as; in his/her opinion is necessary for my care.
Patient / Guardian's signature (for minors): *_____ * Date: _____

Consent for Medication History: I consent to the use of my medication history from any participating medical information exchanges.

Ancillary Services: I understand that PIPFH and other independent labs may be performing laboratory studies as ordered by my physician and collected at PIPFH. These studies will be billed to me by PIPFH lab. I understand that my insurance may not cover these services, and that I am fully responsible for these charges.

Release of Information: Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to the person you designate. Please complete the section below.

Consent to Release of immunization records to other Organizations/Schools: *Yes ( ) No ( ).
*Organizations/School Name (s): _____

Receipt of Notice of Privacy Policy**: I have received/reviewed ( ) or declined ( ) a copy of the Notice of Privacy Policy titled: "Your information. Your rights. Your responsibilities".**

I authorize PIPFH to release any information required in the course of my examination or treatment to the following designated persons:

*Name: _____ *Name: _____
*Relationship: _____ *Relationship: _____
*Current Phone #: _____ *Current Phone#: _____

*Patient Signature: _____ Date: _____
*Guardian's Signature (**for minors**): _____ Date: _____