**Pediatric Providers**
4000 Old Court Road, Suite 205, Pikesville, MD 21208
Phone: 410-484-9950 Fax: 410-484-9953 Email: admin@pediatricproviders.com

# PATIENT REGISTRATION / DEMOGRAPHICS

## CHILD'S INFORMATION

**Child's Legal Name (Last, First, Middle):** _____

**Date of Birth:** _____ **Age:** _____ **Today's Date:** _____

**Sex at Birth:** □ Male □ Female □ Intersex □ Unknown

**Gender Identity (optional):** □ Boy/Man □ Girl/Woman □ Non-binary □ Prefer not to say □ Other

**Race:** □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Multiracial □ Other/Unknown

**Ethnicity:** □ Hispanic/Latino □ Not Hispanic/Latino □ Unknown/Declined

**Main Language Spoken at Home:** _____

Do you need an interpreter? □ Yes □ No

**Social Security Number:** _____

## HOME ADDRESS

**Street Address:** _____

**Apt / Unit #:** _____

**City:** _____ **State:** _____ **ZIP:** _____

## PARENT OR GUARDIAN 1

**Name (Last, First, MI):** _____

**Relationship:** □ Mother □ Father □ Stepparent □ Legal Guardian □ Foster Parent □ Other

**Date of Birth:** _____ **Cell Phone:** _____

**Home Phone:** _____ **Work Phone:** _____

**Email Address:** _____

**Employer / Job:** _____

**Custody:** □ Sole Legal Custody □ Joint Legal Custody □ Other (attach documents)

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# PATIENT REGISTRATION / DEMOGRAPHICS

## PARENT OR GUARDIAN 2

**Name (Last, First, MI):** _____

**Relationship:** □ Mother □ Father □ Stepparent □ Legal Guardian □ Foster Parent □ Other

**Date of Birth:** _____ **Cell Phone:** _____

**Home Phone:** _____ **Work Phone:** _____

**Email Address:** _____

**Employer / Job:** _____

## SIBLINGS ALREADY IN OUR PRACTICE

If you have other children who are already patients here, please list them below. This helps us link your family records and makes check-in easier.

| Sibling's Full Name (Last, First) | Date of Birth | Sex at Birth | Currently a Patient Here? |
|---|---|---|---|
| | | □ M □ F □ Other | □ Yes □ No |
| | | □ M □ F □ Other | □ Yes □ No |
| | | □ M □ F □ Other | □ Yes □ No |
| | | □ M □ F □ Other | □ Yes □ No |
| | | □ M □ F □ Other | □ Yes □ No |

If a sibling is not yet a patient here and you would like to add them, please ask our front desk for a new patient packet.

## PEOPLE WHO CAN APPROVE CARE IN MY ABSENCE

I give the following people permission to approve routine medical care for my child if I am not available:

**Person 1 Name:** _____

**Relationship:** □ Grandparent □ Aunt/Uncle □ Adult Sibling □ Family Friend □ Other

**Phone:** _____

**Person 2 Name:** _____

**Relationship:** □ Grandparent □ Aunt/Uncle □ Adult Sibling □ Family Friend □ Other

**Phone:** _____

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# PATIENT REGISTRATION / DEMOGRAPHICS

## EMERGENCY CONTACTS

Please list up to 3 people we can call in an emergency if we cannot reach a parent or guardian.

**Emergency Contact 1**

**Full Name:** _____

**Relationship:** □ Parent □ Grandparent □ Aunt/Uncle □ Sibling □ Family Friend □ Other

**If Other, explain:** _____

**Main Phone:** _____ **Other Phone:** _____

**Email:** _____

Can this person pick up the child from appointments? □ Yes □ No

Do they live in the same home? □ Yes □ No

**Emergency Contact 2**

**Full Name:** _____

**Relationship:** □ Parent □ Grandparent □ Aunt/Uncle □ Sibling □ Family Friend □ Other

**If Other, explain:** _____

**Main Phone:** _____ **Other Phone:** _____

**Email:** _____

Can this person pick up the child from appointments? □ Yes □ No

Do they live in the same home? □ Yes □ No

**Emergency Contact 3**

**Full Name:** _____

**Relationship:** □ Parent □ Grandparent □ Aunt/Uncle □ Sibling □ Family Friend □ Other

**If Other, explain:** _____

**Main Phone:** _____ **Other Phone:** _____

**Email:** _____

Can this person pick up the child from appointments? □ Yes □ No

Do they live in the same home? □ Yes □ No

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# PATIENT REGISTRATION / DEMOGRAPHICS

## REFERRAL AND PHARMACY

**How did you find us?** □ Doctor Referral □ Insurance List □ Friend/Family □ Google/Web □ Social Media □ Other

**Referring Doctor (if any):** _____

**Preferred Pharmacy Name and Address:** _____

**Pharmacy Phone:** _____

## YOUR CONTACT PREFERENCES

Please choose how you would like us to contact you:

**Best way to reach me:** □ Cell Phone □ Home Phone □ Email □ Patient Portal □ Text Message

**Best Phone Number:** _____

**Best Email Address:** _____

May we leave a voicemail at this number? □ Yes □ No

May we leave a message with another person who answers? □ Yes □ No

**If yes, who may receive a message?** _____

## PATIENT PORTAL

Our secure online patient portal lets you: view your child's medical records, see test results, request appointments, send non-urgent messages to our staff, and view billing information.

**Portal Email Address (if different from above):** _____

Portal setup instructions will be emailed to you after enrollment. Please contact our office if you need help.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Print Name Relationship to Child

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# INSURANCE & MEDICAID INFORMATION FORM

## PRIMARY (MAIN) INSURANCE

**Insurance Company Name:** _____

**Plan Name:** _____

**Member ID:** _____ **Group Number:** _____

**Name on the Insurance Card (Subscriber):** _____

**Subscriber Date of Birth:** _____ **Last 4 of Subscriber SSN:** _____

**Subscriber's Relationship to Child:** □ Self □ Spouse/Partner □ Parent □ Other

**Insurance Phone Number (on back of card):** _____

## SECONDARY (SECOND) INSURANCE

Does the child have a second insurance plan? □ Yes □ No

**Insurance Company Name:** _____

**Member ID:** _____ **Group Number:** _____

**Name on the Insurance Card:** _____

**Subscriber's Relationship to Child:** □ Self □ Spouse/Partner □ Parent □ Other

## MEDICAID / MARYLAND CHILDREN'S HEALTH PROGRAM (MCHP)

Is the child enrolled in Maryland Medicaid or MCHP? □ Yes □ No

**Medicaid ID Number:** _____

**Managed Care Organization (MCO) Name:** _____

**Primary Care Doctor Listed on Medicaid Card:** _____

Note: If the doctor listed on your child's Medicaid card is not a doctor at our office, we will need to request a change before we can bill Medicaid. Please let our billing team know.

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# INSURANCE & MEDICAID INFORMATION FORM

## NO INSURANCE

Please check below if:

□ My child does not have insurance right now. Please tell me about Maryland Medicaid, MCHP, or reduced-cost care options.

## PERMISSION TO BILL

I give this practice permission to check my child's insurance, get any approvals needed, and send bills on my child's behalf. I understand that I am responsible for any costs not covered by insurance, such as co-pays, co-insurance, and deductibles. These are due at the time of the visit.

Signature of Parent or Legal Guardian

Date

Print Name

Relationship to Child

Please bring your insurance card(s) to every visit. Tell us right away if your insurance changes.

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# PEDIATRIC MEDICAL & FAMILY HISTORY

**Child's Full Name:** _____ **Date of Birth:** _____ **Age:** _____ **Sex:** _____ **Today's Date:** _____

**Form Completed By:** _____ **Relationship to Child:** _____ **Primary Language:** _____

## PREGNANCY & BIRTH HISTORY

Illnesses during pregnancy? □ Yes □ No Describe:
Medications during pregnancy? □ Yes □ No Describe:
Alcohol / drug use during pregnancy? □ Yes □ No Describe:
Problems at birth? □ Yes □ No Describe:
Type of delivery: □ Vaginal □ C-Section □ VBAC

**Birth Weight:** _____ **Discharge Weight:** _____

**Hospital Where Born:** _____ **Weeks Early/Late:** _____

Did baby stay in NICU? □ Yes □ No
**If yes, how long and why:** _____

Hepatitis B vaccine given at birth? □ Yes □ No
**Hep B Immunization Date:** _____
Newborn Hearing Screen passed? □ Yes □ No

## PSYCHOSOCIAL HISTORY

Are parents working? □ Mother: Yes □ No □ Father: Yes □ No

**Mother's Date of Birth:** _____ **Father's Date of Birth:** _____

Foster Care? □ Yes □ No

**Foster Care Dates (if applicable):** _____

Currently in a shelter? □ Yes □ No
Housing: □ Rent □ Own □ Other

**Who lives in the household?** _____

**Who cares for the child during the day?** _____

**Number of people in home:** _____ **Number of children:** _____

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# PEDIATRIC MEDICAL & FAMILY HISTORY

## PAST MEDICAL HISTORY

**Health problems / diagnoses:** _____

**Hospital stays (reason & date):** _____

**Surgeries / procedures (type & date):** _____

## HOME & SCHOOL

**Who lives in the home?** _____

Anyone in the home smoke? □ Yes □ No

**Pets in the home:** _____

**School or daycare name:** _____

Grade / Level: □ Infant/Toddler □ Pre-K □ K □ 1–3 □ 4–6 □ 7–9 □ 10–12 □ Not enrolled

**Main caregiver during the day:** _____

## CURRENT MEDICATIONS

List all medicines including vitamins & supplements:

**Medicine 1 — Name / Dose / Frequency:** _____

**Medicine 2 — Name / Dose / Frequency:** _____

**Medicine 3 — Name / Dose / Frequency:** _____

**Medicine 4 — Name / Dose / Frequency:** _____

## ALLERGIES

| Allergen | Type | Reaction |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## CHILD'S MEDICAL HISTORY — Has your child ever had:

| Condition | No | Yes | | Condition | No | Yes |
|---|---|---|---|---|---|---|
| Asthma | □ | □ | | Kidney Disease / Bladder Infections | □ | □ |
| Chicken Pox (Year: _____) | □ | □ | | Physical or Learning Disabilities | □ | □ |
| Frequent Ear Infections | □ | □ | | Bleeding Disorders / Hemophilia | □ | □ |
| Vision or Hearing Problems | □ | □ | | Sexually Transmitted Diseases | □ | □ |
| Skin Problems / Eczema | □ | □ | | Emotional or Behavioral Problems | □ | □ |
| TB / Lung Disease | □ | □ | | Depression / Suicidal Thoughts | □ | □ |
| Seizures / Epilepsy | □ | □ | | Hospitalizations / Surgeries | □ | □ |
| High Blood Pressure | □ | □ | | Physical / Emotional / Sexual Abuse | □ | □ |
| Heart Defects / Disease | □ | □ | | Bone or Joint Injuries | □ | □ |
| Liver Disease / Hepatitis | □ | □ | | Obesity / Eating Disorders | □ | □ |
| Diabetes | □ | □ | | Other (describe below): | □ | □ |

**Other / Additional details:** _____

## FAMILY HEALTH HISTORY — Has anyone in the family (parents, grandparents, aunts/uncles, siblings) had:

| Condition | No | Yes | If Yes, Who | | Condition | No | Yes | If Yes, Who |
|---|---|---|---|---|---|---|---|---|
| Asthma | □ | □ | | | Cancer | □ | □ | |

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# PEDIATRIC MEDICAL & FAMILY HISTORY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| TB / Lung Disease | □ | □ | | Birth Defects | □ | □ | |
| HIV / AIDS | □ | □ | | Hearing Loss | □ | □ | |
| Suicide Attempts | □ | □ | | Speech Problems | □ | □ | |
| Heart Disease | □ | □ | | Kidney Disease | □ | □ | |
| High Blood Pressure / Stroke | □ | □ | | Alcohol / Drug Abuse | □ | □ | |
| High Cholesterol | □ | □ | | Hepatitis / Liver Disease | □ | □ | |
| Blood Disorders / Sickle Cell | □ | □ | | Thyroid Disease | □ | □ | |
| Diabetes | □ | □ | | Learning Problems / ADD / ADHD | □ | □ | |
| Seizures | □ | □ | | Family Violence | □ | □ | |
| Mental Illness | □ | □ | | Other (describe below): | □ | □ | |

**Other / Additional notes on family health:** _____

## GROWTH & DEVELOPMENTAL HISTORY (Complete for children under 6 — write age in months or years)

| Milestone | Age | | Milestone | Age | | Milestone | Age | | Milestone | Age |
|---|---|---|---|---|---|---|---|---|---|---|
| Rolled Over | | | Crawled | | | First Word | | | Walked | |
| Sat Alone | | | Toilet Trained (Day) | | | Said 2-Word Phrases | | | Toilet Trained (Night) | |

Developmental concerns? □ Yes □ No

**If yes, describe:** _____

Signature of Parent or Legal Guardian _____ Date _____ Relationship to Child _____

Print Name _____ Reviewed by (Staff) _____ Date of Review _____