PATIENT DEMOGRAPHIC FORM

Patient name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____

PARENT INFORMATION: (List person or insured name responsible for bill – use legal name)

Person responsible for bill: _____ Mother _____ Father _____ Other Name: _____

Mother's Name: _____

Mother's Work Phone: _____ Cell #: _____

DOB: _____ SS#: _____

Father's Name: _____

Father's Work Phone: _____ Cell #: _____

DOB: _____ SS#: _____

Address (if different from above): _____

Emergency Contact: _____ Phone #: _____

INSURANCE INFORMATION: (PLEASE BRING INSURANCE CARD EACH OFFICE VISIT)

Primary Insurance: _____

Policy Holder's Name: _____

Group #: _____ ID#: _____

Policy Holder's DOB: _____

Secondary Insurance: _____

Policy Holder's Name: _____

Group #: _____ ID#: _____

Policy Holder's DOB: _____

Pharmacy Name: _____

Pharmacy Location: _____

(Initial here) _____ I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORD OF ANY TREATMENT OR EXAMINATION RENDERED MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO KIDZCARE.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MYSELF OR MY DEPENDENT.

SIGNED: _____ DATE: _____

Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Today's Date	Relationship:

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B Immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

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

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

Work Telephone: _____

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

Written Communication

☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to text to this number: _____

☐ Other: _____

Patient Signature: _____
Date: _____

Print Name: _____
Birth Date: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended

purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

Check this box if the disclosure is authorized ☐

Type key:
T = Treatment Records
P = Payment Information
O = Healthcare Operations
A = Authorization on File
D = Discretionary

How disclosure was made:
F = Fax P = Phone E = Email M = Mail O = Other

RECORD RELEASE REQUEST

PEDS WORLD ASSOCIATES
3449 WILKENS AVE SUITE 308
BALTIMORE, MD, 21229
PHONE- (410)-646-1200
FAX- (410)-646-1211

Date:_____

Attention: NR _____

Phone # :_____ Fax # :_____

SEND TO DR. DORA RIOJA-MAZZA

I hereby authorize you to release to dr. Rioja-Mazza any information including the diagnoses and records of any treatment or examination rendered to me during the period of care.

Immunization Records **Recent Notes** **Labs** **All Records**

Patient Name:_____

Date Of Birth:_____

Parent/Guardian Name Print:_____

Signature:_____

Address:_____

_____

Phone #:_____