Bethesda Pediatrics Health History

Date: ______________

Demographic Information

Patient's Name:__________________________ Sex: M/F/ Other Date of Birth:________________

Preferred Name: ______________ Patient's Previous Pediatrician (name & phone #): ______________________________

Person completing this form:______________________ Relationship: ______________

Is this child yours by: ☐birth ☐adoption ☐marriage (stepchild) ☐other:____________________

Parent 1: Name: ______________________ Parent 2: Name: ______________________

Occupation: __________________ Occupation: __________________

Primary Phone #: ________________ Primary Phone #: ________________

Secondary Phone #: ______________ Secondary Phone #: ______________

Address: ____________________ Address: ____________________

Parent's Marital Status: ___________________________

If parents reside at separate addresses, which address is the patient's primary? Parent 1/Parent 2

Beside patient and parent(s), who resides at patient's primary address? ______________________________

Is the patient currently taking any prescription medication? If yes, please list: ______________________________

____

Is the patient currently taking any over the counter medication, vitamins, or herbal supplements?

If yes, Please list: ____

If patient regularly sees any specialists, please list doctor's name & specialty: ______________________________

How did you hear about Bethesda Pediatrics? (if referred by a friend, please include name) ______________________

Pregnancy/Child's Birth History

Illnesses during pregnancy? No Yes

Any medications during pregnancy? No Yes

Any alcohol during pregnancy? No Yes

Problems at birth? No Yes

If yes, please describe: ____________________

Type of delivery? Vaginal C-section

Birth Weight__________ Discharge Weight__________

Name of Hospital: ______________________

City, State/Country: __________________

Did the baby receive the Hepatitis B vaccine? No Yes

Date of Hepatitis B immunization:______________

Was first PKU/metabolic screen done? No Yes

If the hearing test was done, was it passed? No Yes

Social History

Who cares for child? ____________________

School/Daycare? ______________________

Grade? _________ Report card? ______________

School problems? No Yes

Any firearms at home? No Yes

Any pets at home? No Yes

Any exposure to tobacco smoke at home? No Yes

Custody concerns? No Yes

If you answered "yes " to any of the above, please explain:

____

____

Patient's Health History

Has your child ever had any of the following? If yes, please describe:

Condition	No	Yes	If yes, please describe
ADHD/Learning problems	No	Yes	______________
Allergies, including to medications	No	Yes	______________
Asthma/Wheezing/Lung Disease	No	Yes	______________
Bleeding Disorders/Hemophilia	No	Yes	______________
Broken bones	No	Yes	______________
Croup	No	Yes	______________
Developmental Delays	No	Yes	______________
Diabetes	No	Yes	______________
Emotional Problems/Suicide Attempts	No	Yes	______________
Frequent ear infections	No	Yes	______________
Handicaps/Disabilities	No	Yes	______________
Heart Defects/Disease	No	Yes	______________
Hospitalizations/Surgeries	No	Yes	______________
Kidney Disease/Bladder Infections	No	Yes	______________
Measles/Mumps/Chicken Pox	No	Yes	______________
Obesity/ eating disorder	No	Yes	______________
Physical/Emotional Abuse	No	Yes	______________
Seizures/Epilepsy	No	Yes	______________
Skin Problems	No	Yes	______________
Vision/Hearing Problems	No	Yes	______________

Other? Describe: ____

Patient's Name: ___________________________

Family History: Please indicate with an "x" all relatives of the patient with any of the following condition

Date of Birth:_____________________________

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Aunt/ Uncle	Explain
Alcohol/Drug Abuse										
Allergies										
Asthma										
Attention Deficit Disorder										
Autoimmune Disease										
Birth Defects										
Blood Disorders										
Cancer (indicate age)										
Diabetes										
Family Violence										
Genetic Disorder										
GI Problems										
Hearing/Speech Problems										
Heart Disease (indicate age)										
Hepatitis/Liver Disease										
High Blood Pressure										
High Cholesterol										
Hip Dislocation/Dysplasia										
Kidney Disease										
Learning Problems										
Mental Health Issues/Depression										
Mental Retardation										
Seizures										
Strabismus/Lazy Eye										
Stroke										
Thyroid Disease										
Tobacco Use										

Bethesda Pediatrics

Tuberculosis Screening

Patient Name: ________________________ Person Completing Form: _________________

Date of Birth: ____/____/____ Today's Date: _____/____/____

QUESTION	YES	NO
Has the patient had tuberculosis or had a positive screening test (PPD, TB Quantiferon, or T-Spot)?		
Has the patient had HIV, AIDS, any chronic immune disorder, is immune-suppressed due to medication?		
Did the patient had recent close contact with someone with TB?		
Does the patient or close family member work or volunteer in a high risk setting (long term care facility, hospital, and/or shelter)?		
Does the patient have symptoms of TB (persistent cough, fever, night sweats, loss of appetite, weight loss)?		
Was the patient or family member BORN IN, LIVED IN or VISITED FOR MORE THAN 1 MONTH ANYWHERE OVERSEAS? *		

* If the answer is yes to last question, please state where and time of stay below:

____.

____.

____.

____.

Bethesda Pediatrics

Lead Risk Assessment

Patient Name: _________________________ Child's Age: _____

Date of Birth: _____/_____/_______ Today's Date: ____/____/____

QUESTIONNAIRE	**YES**	**NO**
1. In what ZIP Code does the child **currently** live? _____________ Is the above ZIP code listed at the bottom of this questionnaire?		
2. Has your child **ever** lived in any of the "At Risk" zip codes listed at the bottom of this questionnaire? If so, please provide which ones:		
3. Has your child ever lived or stayed in a house or apartment that is built before 1960 (includes day care center, preschool home, home of babysitter or relative)?		
4. Has your child ever lived outside the United States or recently arrived from a foreign country?		
5. Is anyone in the home being treated or followed for lead poisoning?		
6. Are there any renovations or peeling paint in a home that your child regularly visits?		
7. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc)?		
8. Are there any family members who are currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc)?		
9. Does your family use products from other countries such as health remedies, traditional remedies, spices, cosmetics or other products canned or packaged outside the United States? Do you store or serve food in leaded crystal, pottery or pewter? Examples: Glazed pottery, Greta, Azarcon (Rueda, Coral, Liga), Litargirio, Surma, Kohl (Alkohl), Pay-loo-ah, Ayurvedic medicine, Ghassard.		

At Risk Zip Codes:

Montgomery- 20783, 20787, 20812, 20815, 20816, 20818, 20838, 20842, 20868, 20877, 20901, 20910, 20912, 20913

Frederick- 20842, 21701, 21703, 21704, 21716, 21718, 21719, 21727, 21757, 21758, 21762, 21769, 21776, 21778, 21780, 21783, 21787, 21791, 21798

Prince George's- 20703,20710, 20712, 20722, 20731, 20737, 20738, 20740, 20741, 20742, 20743, 20746, 20748, 20752, 20770, 20781, 20782, 20784, 20785, 20787, 20788, 20790, 20791, 20792, 20799, 20912, 20913

---Patient Information--

Last name: ________________________ First name: ______________________ MI: ______

Address:____

City: _______________________ State: _______________ Zip Code : _____________

Sex: M/F/Other ______________ Birthdate: ______________________________

Home Phone: (________)_________________________ Work Phone: (________)__________________________

Cell Phone: (________)__________________________ Cell Phone: (________)____________________________

Parent Email address: ____

------------------Primary Insurance Coverage —-----------------Secondary Insurance Coverage---------------------------

Company: ______________________________

Insured Name: ___________________________

Relationship: _______________ DOB: _______

Co-Pay Amount: __________________________

Policy Number: ___________________________

Group Number: ___________________________

Employer: ______________________________

Company: _______________________________

Insured Name: ____________________________

Relationship: ________________ DOB: _______

Co-Pay Amount: __________________________

Policy Number: ___________________________

Group Number: ___________________________

Employer: _______________________________

---Guarantor Information---

Guarantor:____

Address: ____

City: __________________________________ State: _________________ Zip code: _____________

Phone Number: (_________)_____________________________

May we leave messages containing medical information on your:

Home voicemail? Please initial: Yes _________ No _________

Cell Phone? Please Initial: Yes _________ No _________

Signature of Subscriber or Beneficiary________________________________ Date_____________________

Bethesda Pediatrics

OFFICE POLICY

Patient Name: ____

Date of Birth: ____

Welcome to Bethesda Pediatrics. It is our goal to treat you with respect and understanding in the most professional way possible. Please read the following carefully.

It is mandatory for us to see your insurance card and driver's license at each visit in order for us to be compliant with HIPAA and/or insurance regulations. We can scan and save your driver's license and insurance card for your convenience.

Our office will gladly file to your insurance on your behalf and we will provide them with all necessary documentation of your visit. Bethesda Pediatrics is neither an agent nor an employee of any insurance company. If for any reason your insurance does not pay for services rendered by Bethesda Pediatrics, you, the patient, are solely responsible for the balance. You are ultimately responsible for knowing and understanding your policy, its benefits, and its exclusions and limitations. Bethesda Pediatrics cannot submit claims relating to motor vehicle accidents to your medical insurance. Payment is required at the time of service and you will be provided with a statement to submit to your automobile insurance company. Billing statements are only sent to one address.

Newborns must be added to your insurance policy within several days of birth.

All co-pays/outstanding balances are to be paid upon registration at each office visit. The caregiver (parent, relative, childcare provider) registering the patient is financially responsible for all co-pays/outstanding balance regardless of custody arrangements. Our office accepts cash, checks, Visa, and Mastercard.

Physical exam and conference appointments for existing patients not canceled or rescheduled 24 hours prior to appointment will be charged a $50.00 cancellation fee. When an appointment is missed, you will receive a letter documenting the missed appointment. If three appointments are missed within a 12-month period, the patient and his/her/their siblings will be subject to dismissal from the practice. There is a $20.00 fee for each camp/activity, school, and daycare form completed as well as for letters of medical necessity. There is a $35 returned check fee.

Credit Card on File Requirement for NEW Patients:
All new patients are required to provide a valid credit card on file at the time of registration. This card will only be used to cover fees associated with missed appointments, including a $100 cancellation fee for physical exams and conference appointments not canceled or rescheduled at least 48 hours in advance. The card may also be used for any additional missed appointment fees as outlined in our office policy. Your card information will be stored securely in our encrypted payment system.

Routine Exams with Additional Services: During well child exams, there are times when additional charges may be warranted because the scope of services goes beyond what is considered routine. Copays and deductibles may apply when these services are billed.

Consent to treat:
The following people (OTHER THAN PARENTS) are authorized to bring your child to our office and make medical decisions in your absence. The permission remains valid until notified in writing of any changes.

Name:___________________________________

Relationship:______________________________

Name:___________________________________

Relationship:_____________________________

I, _________________________________, hereby acknowledge that I have read and completely understand the above policies as stated. Any collection fees incurred for breach of this agreement will be the sole responsibility of the undersigned parent/guardian. I acknowledge the office's HIPAA policies regarding the use and disclosure of health information and understand that I can request a copy of the policies at any time.

Parent/Guardian Signature:_______________________

Date____________________

Bethesda Pediatrics

CREDIT CARD ON FILE AUTHORIZATION FORM

Patient Name(s):

____

____

____

Responsible Party Name:

____

Relationship to Patient:

____

Phone Number:

____

Purpose of Card on File

Bethesda Pediatrics requires all new patients to keep a valid credit card on file. This card will be used only for:
- Missed appointment fees, including the $100 fee for physical exams or conference appointments not canceled or rescheduled at least 24 hours in advance
- Any additional missed appointment fees as outlined in our Office Policy
- Returned check fees, if applicable

Your card will not be used for co-pays or routine balances unless you request it. Your information is stored securely in our encrypted payment system.

Credit Card Information

Card Type: Visa ____ Mastercard ____ AmEx ____ Discover ____

Name on Card:____

Card Number:____

Expiration Date (MM/YY):____

Billing Zip Code:

____

Authorization

I authorize Bethesda Pediatrics to charge my credit card for missed appointment fees and other applicable fees as described above. This authorization will remain in effect until I provide written notice of cancellation.

Signature of Responsible Party:

_______________________________Date____________________