Bethesda Pediatrics Health History

Date: _____

Demographic Information

Patient's Name:_____ male/female Date of Birth:_____

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 baby receive Hepatitis B vaccine?	No	Yes

Date of Hepatitis B immunization:_____

Was first PKU/metabolic screen done?	No	Yes
If 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:
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 conditions. 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										

Patient Name: _____

Date of Birth: _____

Tuberculosis Risk Assessment
(Initial visit and yearly thereafter)

	Date	Date	Date	Date
Has your child or anyone in the household been born in, or lived more than 1 year in a country other than the U.S.? When/Where_____	Y/N	Y/N	Y/N	Y/N
Has your child been exposed to anyone with active TB or a history of TB disease?	Y/N	Y/N	Y/N	Y/N
Is your child currently living in a household with anyone who is HIV positive?	Y/N	Y/N	Y/N	Y/N
Is your child part of a migrant worker family?	Y/N	Y/N	Y/N	Y/N

Lead Risk Assessment
(For patients under 6 years of age)

	Date	Date	Date	Date
Does your child live or has he/she ever lived in a house or apartment built before 1960?	Y/N	Y/N	Y/N	Y/N
Is anyone in the home being treated or followed for lead poisoning?	Y/N	Y/N	Y/N	Y/N
Are there any renovations or peeling paint in any location that your child regularly visits? (Daycare, preschool, babysitter, relative?)	Y/N	Y/N	Y/N	Y/N
Is there any family member who is currently working in an occupation where lead exposure could occur?	Y/N	Y/N	Y/N	Y/N
Does your child currently live or has he/she previously lived in any of the zip codes listed below?	Y/N	Y/N	Y/N	Y/N

Montgomery County:	20783, 20787, 20812, 20815, 20816, 20818, 20838 20842, 20868, 20877, 20901, 20910, 20912, 20913
Frederick County:	20842, 21701, 21703, 21704, 21716, 21718, 21719, 21727, 21757, 21758 21762, 21769, 21776, 21778, 21780, 21783, 21787, 21791, 21798
PG County:	20703, 20710, 20712, 20722, 20731, 20737, 20738, 20740, 20741, 20742, 20743 20746, 20748, 20752, 20770, 20781, 20782, 20783, 20784, 20785, 20787, 20788

----------Patient Information----------

Last name: _____ First name: _____ MI: _____

Address: _____

City: _____ State: _____ Zipcode : _____

Sex (M/F): _____ Birthdate: _____ Social Security: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Cell Phone: (_____)_____

Email address: _____

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

Company: _____ Company: _____

Insured Name: _____ Insured Name: _____

Relationship: _____ DOB: _____ Relationship: _____ DOB: _____

Co-Pay Amount: _____ Co-Pay Amount: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Employer: _____ 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
11325 Seven Locks Road #238, Potomac, MD 20854
301-299-8930

2019 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 sent to only 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 balances regardless of custody arrangements. Our office accepts cash, checks, Visa and Master Card.

Physical exam and conference appointments 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 or her 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 **$35.00 returned check fee**.

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. This 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.

Parent/Guardian signature_____ Date_____