

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?	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: _____			

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 (Alkohol), 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: _____

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

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 _____