Riverdale Park Pediatrics, P.C
Patient Registration Form

Today's Date: _____

Patient Information

Name: _____

Date of birth: _____ Social Security # _____ Sex: __ M __ F

Home Address: _____

City: _____ State: _____ Zip Code _____

Parent / Guardian Information

Mother's Name: _____ Date of birth: _____

Cell Phone: _____ Work Phone: _____

Home Address (if different from child) _____

City: _____ State: _____ Zip: _____

Email address: _____ Social Security # _____

Father's Name: _____ Date of birth: _____

Cell Phone: _____ Work Phone: _____

Home Address (if different from child) _____

City: _____ State: _____ Zip: _____

Email address: _____ Social Security # _____

Emergency Contact: (relative or friend): _____ Phone#: _____

Insurance Information

Primary Insurance: _____ Policy #_____

Group # _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber Social Security# _____

Patient relationship to subscriber: _____ Employer: _____

Employer Address_____

Employer phone # _____

Secondary Insurance: _____ Policy #_____

Group # _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber Social Security# _____

Patient relationship to subscriber: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Riverdale Park Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian signature_____ Date _____

Riverdale Park Pediatrics PC
6103 Baltimore Ave. T-1
Riverdale, MD 20737
Phone (301) 277-2779 Fax (301) 277-6947

CONSENT FOR TREATMENT OF A MINOR

I,_____ The parent or guardian of _____, who i.e. a minor, authorize **Riverdale Park Pediatrics, P.C** and all persons acting as agents thereof and all physicians to whom said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to **Riverdale Park Pediatrics,P.C.**

AUTHORIZATION AND RELEASE

I authorize **Riverdale Park Pediatrics** to release any information including the diagnosis and the records of any treatment or examination rendered to 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 directly to **Riverdale Park Pediatrics** insurance benefits otherwise payable to me.

PAYMENT POLICY

I understand that if **Riverdale Park Pediatrics/ Edwin Aguilar,M.D** is not contracted with my insurance carrier, I must pay in full at the time of service. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that some services provided by **Riverdale Park Pediatrics,P.C** may not be covered by my benefit plan. I agree to be responsible for payment of all services rendered. I understand that all Co-payments, Co-insurance and Deductibles are due at the time of service. I understand that any balance generated is due within 10 days of the billing day unless other arrangement is made. I realize that failure to keep this account current may result in **Riverdale ParkPediatrics**, being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

NEW BABY

I fully understand that my newborn baby needs to be added to my insurance policy by the two week appointment. If my newborn baby has not been added to the policy or does not have health insurance I am aware that I am responsible for the office fee at the time services are rendered.

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM, NAMELY THE SECTIONS TILTLED: CONSENT TO TREATMENT OF A MINOR, AUTHORIZATION AND RELEASE AND PAYMENT POLICY. I AM THE PARENT OF SAID MINOR CHILD, OR THE COURT-APPOINTED GUARDIAN FOR THE PATIENT AND I AM AUTHORIZED TO ACT ON THE PATIENT'S BEHALF TO SIGN THIS RELEASE OF INFORMATION.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN OF PATIENT DATE

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information. I understand that Riverdale Park Pediatrics P.C has the right to change its notice of Privacy Practices from time to time and that I may contact Riverdale Park Pediatrics, P.C at any time in writing at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or heath care operations. I also understand that you are not required to agree to my requested restrictions if it not feasible for RPP, PC to ensure compliance or believe it will negatively impact the care Riverdale Park Pediatrics provides.

Patient's Name:_____

Date of Birth : _____

If patient under 18 years old parent or legal guardian signature required.

Signature: _____ relationship: _____

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:

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STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street, Baltimore, Maryland 21201

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

***Providers must screen and properly document eligibility status at each immunization visit.**

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VFC #: _____

Health Care Provider: _____

Patient: _____ DOB: _____

Date	VFC Eligibility (birth through 18 years of age)					Staff's initials
	Medicaid	Uninsured	Native American/ Alaskan Native	Underinsured (refer to LHD/FQHC)	Not VFC Eligible	