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	d):	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	MANAGAM MANAGAM AND	Date		

Riverdale Park Pediatrics, P.C

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
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.
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 Park Pediatrics, 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.

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Medical Treatment Authorization

Date:	
Ι	authorize the following people to bring
my child	in for treatment in my absence, He / She is
empowered to make medical treatment de	cisions while I am absent and to sign any and all
medical paper work so that my child may	receive proper and prompt medical treatment.
This notice is valid until I provide another	written notice stating otherwise, or until I am present to
make these decisions myself.	
Name:	Relationship:
Sincerely,	
Parent/Guardian Name	Parent/Guardian Signature

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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	1.

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 BIRT	TH HISTORY	PSYCHOSOCIAL HI	STORY	
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		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		MEDICAL HISTORY		
Has anyone in the family (paren aunts/uncles, sisters/brothers) i	ts, grand-parents, nad: Who?	Has your child ever had: Allergies (List)	No □ Yes □	
TB/Lung Disease HIV/AIDS Suicide Attempts Heart Disease High Blood Pressure/Stroke High Cholesterol Blood Disorders/Sickle Cell Diabetes Seizures Mental Illness Cancer Birth Defects Hearing Loss Speech Problems Kidney Disease Alcohol/Drug Abuse Hepatitis/Liver Disease Thyroid Disease Learning Problems/Attention	No Yes	Asthma Chicken Pox (Year) Frequent Ear Infections Vision/Hearing Problems Skin Problems/Eczema TB/Lung Disease Seizures/Epilepsy High Blood Pressure Heart Defects/Disease Liver Disease/Hepatitis Diabetes Kidney Disease/Bladder Infection Physical or Learning Disabilities Bleeding Disorders/Hemophilia Sexually Transmitted Diseases Emotional or Behavioral Problem Depression/Suicidal Thoughts Hospitalizations/Surgeries Physical/Emotional/ Sexual Abus Bone or Joint Injuries Obesity/Eating Disorders Other:	No	
Family Violence I	No 🗆 Yes 🗆	Current Medication(s): (<i>List</i>)	_	
Reviewed by:		Date of Review:		