FILL OUT COMPLETELY-print clearly

New Patient Demographics Info

Pt's Last Name_____ Sex: Female / Male / Transgender

Pt's First Name_____ MI_____ DOB_____

Pt's Address _____ City_____ State_____ Zip_____

Primary Contact Number_____ (reminder calls/text go to this number)

Secondary Contact Number _____

LEGAL CUSTODY: Circle One: Married Mother Father Joint PROVIDE us with updated custody papers.

Responsible Party (statements will be mailed to this parent). Circle One: Mother Father Other_____

Last Name: _____ First Name_____ MI_____

Address _____ City_____ State_____ Zip_____

DOB _____ SSN_____

Phone # _____ Work #_____

Circle One: Mother Father Other_____

Last Name: _____ First Name_____ MI_____

Address _____ City_____ State_____ Zip_____

DOB _____ SSN_____

Phone # _____ Work #_____

Primary Health Insurance Company Name_____

Policy Holder's Name_____ Relationship to Patient_____

Policy Holder's Full Address_____

Policy Holder's DOB_____ Policy Holder's SSN_____

**Primary Email to access Pt Portal (only one email can be used) _____

Race: Circle One: White / Black / Hispanic / Asian / Other: _____

Ethnicity: Circle One: Hispanic or Latino / Not Hispanic or Latino / Refused to Report

Language: Circle One: English / Indian (include Hindi) / Russian / Spanish / Other:_____

Primary Pharmacy Name_____ City_____ State _____

ER Contact and/or Person authorized to see medical treatment for my child in my absence:

Name: _____ Phone #_____ Relationship to Patient: _____

Name: _____ Phone# _____ Relationship to Patient: _____

AUTHORIZATION TO TREAT

I hereby give permission to The Bay Pediatric Center examine and render treatment to the patient listed above.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGN BENEFITS

I authorize The Bay Pediatric Center to apply for benefits for covered services rendered by the Practice, and request that the payments from my insurance carrier be sent directly to the Practice.

ASSUMPTION OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible to the doctor for all charges incurred on my account whether covered by my insurance company or not. These charges are to be paid at the time services are rendered unless submitted to an insurance company with whom The Bay Pediatric Center has a participating contract. I, also, understand that non-covered services under my insurance policy and outstanding balances become my full responsibility. In the event collection proceedings are instituted to enforce payment of fees due to The Bay Pediatric Center. I/We, the undersigned agree to pay the additional sum of thirty percent (30%) for collection fees.

Please read above and sign: _____ Date: _____

I am aware that I could be discharged from the Practice form multiple no show appointments, for which I do not give 24 hours of notice.

Please read above and sign: _____ Date: _____

List of Current Medications:

_____

_____

Medical History of Patient

Birth Weight _____ Gestational Weeks _____ Delivery: Circle One: Vaginal / C-Section

List any pregnancy problems _____

Feedings: Circle One: Breast / Formula: _____

List any infant problems _____

Developmental Milestones

Sat at ___ months Walked at ___ months Talked at ___ months Toilet trained at ___ months

ALLERGIES

List any drug allergies and reactions _____

_____

List any food allergies and reactions _____

_____

SURGICAL HISTORY

List any surgeries and approximate dates_____

_____

HOSPITALIZATIONS

List any hospitalizations and approximate dates_____

_____

FAMILY HISTORY

Father's Name_____ DOB _____ Occupation_____

Mother's Name_____ DOB _____ Occupation_____

Sibling's Name_____ DOB _____ Occupation_____

Sibling's Name_____ DOB _____ Occupation_____

Sibling's Name_____ DOB _____ Occupation_____

Sibling's Name_____ DOB _____ Occupation_____

Please circle appropriate illness or problems of family members of Patient:

Patient	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer: What Kind_____
Father	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer: What Kind_____
Mother	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer: What Kind_____
P GFather	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer: What Kind_____
P GMother	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer: What Kind_____
M GFather	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer: What Kind_____
M GMother	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer: What Kind_____

Enter any other illnesses/problems here_____

_____

SOCIAL HISTORY

Patient lives with_____

Guns in House: Yes / No

Water: Well / Town

Alcohol Use: Yes / No

Drug Use: Yes / No

Family Smoking: Who_____

Type of Housing_____

Pets in House_____

Home heat is_____

Travel to Foreign County: Yes / No

School_____

Grade_____

Hobbies_____

Printed Name of Person filling out this form_____ Signature_____

Relationship to Patient_____

Today's Date_____

The Bay Pediatric Center, LLC
606 Dutchman's Lane
Easton, MD 21601
410-763-8272

PATIENT CONSENT FOR USE AND DICLOSURE OF PROTECTED HEALTH INFORMATION

With the consent, The Bay Pediatric Center, LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to The Bay Pediatric Center's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

The Bay Pediatric Center, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Suzanne Brittingham, Privacy Officer at 606 Dutchman's Lane, Easton, MD 21601.

With the consent, The Bay Pediatric Center, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, The Bay Pediatric Center, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, The Bay Pediatric Center, LLC may e-mail my appointment reminder cards and patient statements. I have the right to request that the The Bay Pediatric Center, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Bay Pediatric Center, LLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Bay Pediatric Center may decline to provide treatment to me.

This authorization is valid from the date signed below and will remain in effect until such time it is revoked by the Parent/Guardian.

_____
Signature of Parent/Guardian or Patient

_____ _____
Print Name of Parent/Guardian or Patient Date

_____
Child(ren)s Name(s)

Bay Pediatric Vaccine Policy

Listed below is our policy on vaccinating children. We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We also believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

We are making you aware of these facts not to scare you but to emphasize the importance of vaccinating your child. We recognize the choice may be an emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.**

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age, all AAP-recommended immunizations by two years of age, and meningococcal vaccine and booster doses of Tdap and varicella vaccines by age 12 years.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

_____ _____

(Signature of Parent/Guardian) (Date)