The Bay Pediatric Center **PATIENT DEMOGRAPHIC**

Patient Name: ____ DOB: ___/___/_____
(last) (first) (middle)

Sex: Male / Female Race: White / Black / Hisp / Asian / Other: ________________

Address of Child:

Street: ____

City: ____________________, State: _________ Zip: _______

Primary Phone #: (____) ____-________ Secondary Phone #: (____) ____-________

Mother's Information:

Name: ________________________________

Address: ________________________________

City/State/Zip: ___________________________

DOB: ___/___/_____

Home#______________ Work#______________

Cell#______________

Father's Information:

Name: ________________________________

Address: ________________________________

City/State/Zip: ___________________________

DOB: ___/___/_____

Home#______________ Work#______________

Cell#______________

Legal Custody: Married___ **Mother___ **Father___ **Other_________________________

(Please provide court orders to document custody. We cannot see your child without them.)**

Primary Pharmacy: _______________________ City: _________________

Emergency Contact Name: _______________________ Phone # ___________________

**Email to access Patient Portal: ____

INSURANCE INFORMATION

Patient's Insurance Company: _________________________ Policy Holder: _____________________________

Policy Holder SSN: _______________ DOB: ___/___/_____ Relationship to Patient: ____________

Authorization to Treat

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

Financial Patient Agreement (PLEASE INITIAL AT BLANKS TO SHOW YOU READ OUR POLICIES)

I, the undersigned, am aware that I am financially responsible for all services rendered to me by Bay Pediatric Center which includes co-pays, deductibles and non-covered services, as dictated by my insurance coverage. _____

I also authorize Bay Pediatric Center to apply for benefits for covered services rendered by the Practice, and request that the payments from my insurance carrier are paid directly to the Practice. _____

I am aware that if at any time my account is sent to and outside collection agency I will be responsible for payment of an additional 30% of the amount sent. _____

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

I certify that the information I have provided with regard to my identity and insurance coverage is correct, and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. I permit a copy of this authorization to be used in place of the original. _____

Print Name:_________________________ Signature: ______________________ Date: ___________

PLEASE FILL OUT COMPLETELY

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.

____
Signature of Parent/Guardian or Patient

______________________________ __________________
Print Name of Parent/Guardian or Patient Date

____
Child(ren)s Name(s)

Social History

Lives with: ______________________________

Type of Housing: ______________________ Water: ____Well ____Town

Heating System: ______________________________

Pets: ______________________________

Smokers: ____________________ Alcohol/Drug Use Yes____ No____

Last Dental Visit: ________________ Travel to Foreign Country Yes___ No ___

School: ______________________ Grade: ____________

Hobbies: ______________________________

Check if the Patient or member of the family have had the following illnesses or problems

List the Appropriate initials after each (**P**atient, **F**ather, **M**other, **S**ibling, Grandparents: (**MG PG**)

O Alcohol or drug abuse
O Allergies
O Allergy shots
O Drug allergies
O Asthma
O Eczema
O Lead poisoning
O Frequent respiratory infections
O Tuberculosis
O Ear Tubes
O Anemia or blood disorders
O Smokers
O Birth defects

O Diabetes
O Growth problems
O Seizures
O Cholesterol problems
O High blood pressure
O Heart attack/stroke before age 55
O Emotional or behavior problems
O Heredity problems
O Cancer
O Stomach or intestinal problems
O Mental illness
O Other (list below)

____
____
____

Person filling out this form: ______________________________

Relationship to patient: ______________________ Todays date: ____________

Pediatric Patient Information

Patient Name: ______________________________

Date of Birth: ____________________ SSAN: ____________________

Allergies: ______________________________

Previous Doctor: ______________________________

Dentist: ______________________________

Medications: ______________________________

Family Information

	Name	Date of Birth	Occupation
Father:			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

Newborn History

Birth Weight: ____________ Gestational Weeks: ____________

Delivery: ___Vaginal ___ C-Section

Pregnancy Problems: ______________________________

Feedings: ___Breast ___ Formula Name of Formula: ____________

Infant Problems: ______________________________

Developmental Milestones: Sat at ______ Months Walked at _____ Months

Talked at _____ Months Toilet Trained at ______Months

Please list hospitalizations or surgeries and approximate dates:

1) ______________________________

2) ______________________________

3) ______________________________

4) ______________________________

Bay Pediatric Vaccine Policy (Updated 3/16/15)

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 and others 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)