Cross Keys Pediatrics: Patient Registration

PATIENT INFORMATION:

FULL NAME: _____ SEX: ☐ M ☐ F

DOB: _____ BIRTH HOSPITAL: _____

RACE: ☐ ASIAN ☐ AMERICAN INDIAN ☐ BLACK ☐ HISPANIC ☐ WHITE ☐ OTHER: _____

PHONE #: _____ SECONDARY PHONE#: _____

ADDRESS: _____

CITY, STATE ,ZIP: _____

PARENT INFORMATION:

PARENT 1 FULL NAME: _____

PHONE#: _____ WORK #: _____

ADDRESS: _____ CITY,STATE,ZIP: _____

PARENT 2 FULL NAME: _____

PHONE#: _____ WORK#: _____

ADDRESS: _____ CITY,STATE,ZIP: _____

INSURANCE INFORMATION

SECONDARY INSURANCE WILL ONLY BE USED IF IT IS MARYLAND STATE MEDICAID

PRIMARY: _____ POLICY HOLDER: _____ DOB: _____

ID#: _____ GROUP#: _____

SECONDARY: _____ POLICY HOLDER: _____ DOB: _____

ID#: _____ GROUP#: _____

SIGNATURE OF PATIENT/GUARDIAN: _____

PRINT FULL NAME: _____

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

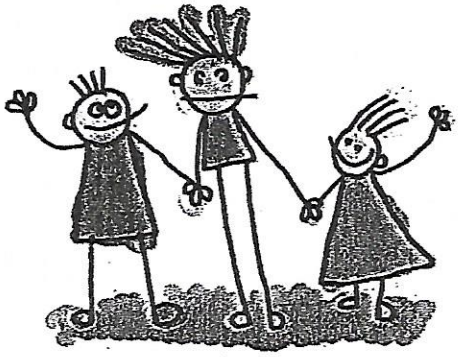
Has your child ever had:

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:

Cross Keys Pediatrics



To: _____

(FORMER PHYSICIAN OR HEALTH CARE FACILITY)

_____

Patient Name: _____

Address: _____

Date of Birth:_____ Age:_____ Sex:_____

We would appreciate a photocopy of the medical records on the above patient who is currently under my care. Thank you!!

Cross Keys Pediatrics

2 Hamill Rd Ste 405

Baltimore, MD 21210

(410) 323-1144

FAX: (410) 323-6161

I authorize the release of the above information to Cross Keys Pediatrics

_____ _____

Patient/Patient Representative Date

_____

Relationship to Patient

Cross Keys Pediatrics & Family
2 Hamill Road
Suite 405
Baltimore, MD 21210
Phone: 410/323.1144 Fax: 410/323.6161

Vaccine Consent

Patient Name _____ DOB _____

I have received vaccine information material from the Centers for Disease Control and Prevention and I have read and had explained to me information about the vaccines my child is to receive. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccines and I give consent for the vaccines to be administered.

Dtap (5 doses)
IPV (4 doses)
HIB (3 doses)
MMR (2 doses)
Hep A (2 doses)
Hep B (3 doses)
HPV (2-3 doses)

Pneumococcal 13 (4 doses)
Varicella (2 doses)
Influenza (yearly)
Tdap (1 dose)
Meningococcal Group B (2 doses)
Meningococcal A, C, Y, W (2 doses)
Rotavirus (3 doses)

Parent or guardian signature Relationship Date