

WHERE EVERY CHILD IS DEAR TO US



Care to Kids
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: _____

EMAIL: _____

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#: _____

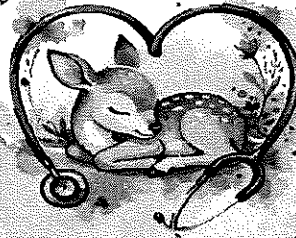
SECONDARY: _____ POLICY HOLDER: _____ DOB: _____

ID#: _____ GROUP#: _____

SIGNATURE OF PATIENT/GUARDIAN: _____

PRINT FULL NAME: _____

WHERE EVERY CHILD IS DEAR TO US



Care to Kids

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!!

CARE TO KIDS PEDIATRICS

ARIELA S. TAUB, M.D.
8890 McDonogh Road, Suite 208
Owings Mills, MD 21117

(410) 323-1144

FAX (410) 323-6161

I authorize the release of the above information to **CARE TO KIDS PEDIATRICS**.

Patient/Patient Representative

Date

Relationship to Patient

CARE TO KIDS PEDIATRICS

ARIELA S. TAUB, M.D.
8890 McDonogh Road, Suite 206
Owings Mills, MD 21117

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