Pediatric Endocrinology Patient Registration

Welcome to our office. In order to facilitate your child's evaluation, please provide us with the following information:

Date of Appointment: _____

Child's Full Name:	Date of Birth:
Mother's Name and Address: _____ _____ _____ Telephone Number: _____	Father's Name and Address: _____ _____ _____ Telephone Number: _____

Primary Insurance Information:

Policy Holder's Name (As it appears on card): _____

Social Security Number of Subscriber: _____

Primary Insurance Company/ Health Plan Name: _____

Policy Holder Date of Birth: _____

Identification/ Policy Number: _____ Group Number: _____

Do you have Secondary Insurance? Yes _____ No _____

Primary Care Physician/ Pediatrician: _____

Physician's Phone #: _____ Fax #: _____

Referring Provider (if different from physician above): _____

Name and phone number of preferred pharmacy: _____

Reason for visit? _____

Has your child had any medical tests performed due to this condition (X-rays, blood, urine, stool tests, etc.)?
Yes _____ No _____

If yes, when/where? _____

Medical History:

Medical Problems or Health Concerns:

1. _____
2. _____
3. _____
4. _____

Prior Hospitalizations (Reason/ Date/ Location):

1. _____
2. _____

Prior Surgeries or Outpatient Procedures (Surgery Name/ Date/ Location):

1. _____
2. _____

Please list any known medication, food, or other allergies:

_____

_____

_____

Current Medications:

Please list medication, dosages, and frequency:

_____

_____

_____

_____

Birth History:

Any problems with pregnancy, labor, delivery? _____

Birth Weight: _____ Birth Length: _____ Gestational Age: _____ weeks

In the first week of life, was the baby jaundiced? Yes _____ No _____

Any medical problems during the first month of life? _____

Social History:

Who lives at home with your child? _____

Has your child traveled outside the U.S. in the past 6 months? _____

Who is involved with the child's care/ food preparation? _____

Current School Grade: _____

Any unusual stresses at home or school? _____

Family History:

Family Member	Height	Weight	Age	Health	Medication	Age of Puberty
Father						
Mother						
Siblings						

Please place a check mark in the appropriate box if any of the listed family members have a condition listed below:

Chronic Medical Conditions	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Diabetes								
Celiac Disease								
Thyroid Disease								
Short Stature								
Bone Disease								
Abnormal Puberty								

Please list any other medical conditions that run in the family that are not mentioned above?

_____

_____

_____

_____

Review of Systems:

Please check the box below if your child has experienced any of the following in the past three months:

General:	Chills	Fatigue	Irritability	Weight Loss/Gain	Fever
Ear, Nose, Throat:	Hearing Loss	Nasal Discharge	Strep Throat	Mouth Sores	Oral Thrush
Skin:	Rashes	Jaundice	Cyanosis	Nail Changes	
Eyes:	Blurred Vision	Eye Pain	Vision Change	Light Sensitivity	
Chest:	Wheezing	Chest Pain	Coughing	Shortness of Breath	
Hematology:	Bleeding Problems	Swollen Glands	Bruises Easily	Muscle Weakness	
Genitourinary:	Bed Wetting	Painful Urination	Frequent Urination	Dark Colored Urine	
Musculoskeletal:	Fractures	Muscle Aches	Bone Deformity	Joint Stiffness/ Swelling	
Neurological:	Headache	Dizziness	Seizures	Loss of Consciousness	

Please list any other symptoms that have been experienced that are not mentioned above?

_____

_____

_____

_____

Has your child been diagnosed with any of the following?

Diagnosis	Y/N	Diagnosis	Y/N
Asthma		ADHD/ADD	
Heart Murmur		Anxiety	
Anemia		Depression	
Diabetes		Other:	

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize Pediatric Endocrinology of Annapolis to discuss appointment dates, times, location, medical history, diagnosis, treatment prognosis, financial, insurance, and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA- compliant authorization. This permission will be considered on-going until I indicate otherwise in writing. Protected Health Information may be release to the following individuals:

_____ _____

_____ _____

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Pediatric Endocrinology of Annapolis' Notice of Privacy Practices, 2020 Revision. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Financial Polices Acknowledgement

I acknowledge that I have received, or had the opportunity to receive a copy of the Financial Policies of Pediatric Endocrinology of Annapolis, LLC while in the office, or on the Pediatric Endocrinology of Annapolis website. I understand that the practice has the right to change its Financial Policies, and that I may contact the practice at any time to obtain a current copy of the Financial Policies.

_____ _____

Patient Name (Print) Responsible Party Name and Relation to patient

_____ _____

Responsible Party Signature Date