13976 Baltimore Avenue, Laurel, MD
831 University Blvd, Suite 32, Silver Spring, MD

301-776-9000
301-439-0099

LAUREL CHILDREN'S CLINIC
REGISTRATION FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's Last Name:	First:		Middle:		Birth Date:
Street address:	Apt:		**Home phone no:**		( )
City:	State:	ZIP Code:	Work phone no:		( )
E-mail:			**Cell phone no:**		( )
Pharmacy Name & Address:			OK to leave message?		□ Yes □ No
Pharmacy Telephone No:			Sex:		□M □F
Occupation:	Employer:		Employer phone no:		( )
Street address: City: State:					ZIP Code:
Mother's /Guardian Name(s):					
Mother's Birth date:					
Who referred you to this office?					
INSURANCE INFORMATION					
Person responsible for bill:	**Birth date:**	**Address (if different):**			**Home phone no:** ( )
Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment: $**
Patient's relationship to subscriber:	□ **Parent** □ **Relative** □ **Friend** □ **Other**				
Primary Insurance Carrier:	**Claim #:**	**Person authorizing treatment:**			**Phone no:** ( )
Street address: City: State:					**ZIP Code:**
Secondary Insurance Carrier (if applicable):	**Subscriber's name:**	**Group no.:**			**Policy no.:**
Patient's relationship to subscriber:	□ Parent □ Relative □ Friend □ Other				
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Daytime phone no: ( )	Evening phone no: ( )		

I hereby authorize and request all payments be made directly to Laurel Children's Clinic, the amount(s) due on a claim for services rendered to my dependents. I will be responsible for payment of the difference(s), according to the explanation of benefits. If the nature of the office visit is not covered by the policy, I understand that I will be financially responsible to pay the provider the amount of the entire bill. I hereby authorize treatment of the patient named above and agree to pay all charges at the time services are rendered, unless other arrangements are agreed upon in advance. If payment of my account are delinquent, or it goes to collection, all fees including collection, attorney fees and applicable finance charges will be my responsibility. I hereby authorize the release of any information necessary for payment of charges incurred.

Patient/Guardian Signature:	***Date:***

Laurel Children's Clinic
13932 Baltimore Avenue
Laurel, Maryland 20707
301-776-9000

CONFIDENTIAL ADOLESCENT HEALTH INVENTORY

(13 - 18 Yrs.)

Please complete both sides

Date:_____ **DOB:** _____ **Age:** ____ **Name:**_____

Please bring in a record of your immunizations for us to copy.

Please ask your healthcare provider about any questions you do not understand

1. What do you like to be called? _____
2. Who lives in your household? (Name, relationship, age)

_____

_____

3. Where do you go to school? _____
4. What grade are you in? _____
5. What are your average grades? _____

History

6. List any health problems you have or had previously: _____

_____

_____

7. List current medications or skin products you are using, including over-the-counter/herbal medications: _____

_____

_____

8. Are you allergic to any medication? ☐ Yes ☐ No

If yes, name/reactions: _____

9. Have you ever been hospitalized? ☐ Yes ☐ No

For what? _____

_____

Nutrition

10. List the things you have eaten in the past 24 hours: _____

_____

_____

11. List the number of servings you have of these foods any day:

_____ bread/pasta _____ milk _____ meat

_____ vegetables _____ fruit

12. Mark the number of meals you eat each day:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

13. Do you use laxatives or vomit (throw up) to keep your weight down? ☐Yes ☐ No

Dental

14. Do you brush your teeth daily? ☐ Yes ☐ No
15. Do you floss your teeth daily? ☐ Yes ☐ No
16. Do you visit a dentist at least once a year? ☐ Yes ☐ No

Safety

17. Do you wear a seat belt in the car? ☐ Yes ☐ No
18. Do you wear a bicycle or motorcycle helmet when you ride? ☐ Yes ☐ No
19. Do you have a smoke alarm in your home? ☐ Yes ☐ No
20. Do you have a fire extinguisher in your home? ☐ Yes ☐ No
21. Do you know how to swim? ☐ Yes ☐ No
22. Are your immunizations (shots) up to date? ☐ Don't know ☐ Yes ☐ No

23. Check any of the following that bother you:

- ☐ your weight
- ☐ your height
- ☐ difficulties sleeping
- ☐ nightmares
- ☐ allergies
- ☐ skin rash
- ☐ insect bite reaction
- ☐ dizzy spells
- ☐ fainting
- ☐ convulsions
- ☐ unconsciousness (knocked out)
- ☐ concussion
- ☐ blurred vision
- ☐ headaches
- ☐ ear aches
- ☐ hearing loss
- ☐ nose bleeds
- ☐ cold sores
- ☐ chest pain
- ☐ difficulty breathing
- ☐ wheezing
- ☐ asthma
- ☐ pneumonia
- ☐ bronchitis
- ☐ hay fever
- ☐ constipation
- ☐ diarrhea
- ☐ stomach aches
- ☐ nausea
- ☐ bleeding from bottom
- ☐ vaginal discharge
- ☐ penile discharge
- ☐ bloody urine
- ☐ bedwetting
- ☐ fractures (broken bones)
- ☐ sports injuries
- ☐ back aches
- ☐ painful bones or joints
- ☐ depression
- ☐ school problems
- ☐ family problems
- ☐ need a counselor

Immunizations

24. Were you born in a foreign country? ☐ Yes ☐ No
25. Have you had close contact with a person infected with TB, or been in jail or a long-term care facility? ☐ Yes ☐ No

Sexuality

26. Have you ever had intercourse (sex)? ☐ Yes ☐ No
27. What method of birth control did/do you use?

_____

28. Did/do you use condoms? ☐ Yes ☐ No
29. Do you want information about pregnancy or birth control? ☐ Yes ☐ No
30. Do you want information about sexually transmitted diseases? ☐ Yes ☐ No
31. Do you think you have ever been exposed to or been treated for an STD (venereal disease)? ☐ Yes ☐ No
32. Do you know what STD (venereal disease) symptoms are? ☐ Yes ☐ No

Social

33. Do you usually expect to succeed in things you do? ☐ Yes ☐ No
34. Do you feel you are liked by most people who know you? ☐ Yes ☐ No
35. Do you feel you get along with your parents? ☐ Yes ☐ No
36. Within the last 12 months, have you been in a relationship in which there were threats, pushing, grabbing, hitting, kicking, breaking things or other hurting used? ☐ Yes ☐ No
37. Within the last 12 months, have you experienced any uncomfortable touching? Forced sexual contacts? Abuse? ☐ Yes ☐ No
38. Do you find it hard to concentrate on a task or job? ☐ Yes ☐ No
39. Have you ever thought about suicide? ☐ Yes ☐ No
40. Do you worry about any other person close to you, such as friends or relatives? ☐ Yes ☐ No
41. Do you want to hurt or cut yourself? ☐ Yes ☐ No

Moods

42. How often do you find yourself affected by any of these moods?

	seldom	occasionally	often
anger	☐	☐	☐
boredom	☐	☐	☐
depression	☐	☐	☐
frustration	☐	☐	☐
loneliness	☐	☐	☐
shyness	☐	☐	☐
stressed out	☐	☐	☐

Health Risks

43. Do you smoke cigarettes? ☐ Yes ☐ No
    If yes, how many per day? _____
44. Do you smoke marijuana? ☐ Yes ☐ No
45. Do you use chewing tobacco or snuff? ☐ Yes ☐ No
46. Do you use cocaine or crack? ☐ Yes ☐ No
47. Do you use speed/meth/crank? ☐ Yes ☐ No
48. Do you drink alcoholic beverages? ☐ Yes ☐ No
49. Do you sniff glue or other aerosols? ☐ Yes ☐ No

Family History

50. Check any of the following problems your parents, brothers, sisters, grandparents, aunts, uncles, or cousins have had, and state who:

	WHO
☐ alcoholism	_____
☐ allergies	_____
☐ asthma	_____
☐ blood disease	_____
☐ cancer	_____
☐ child abuse	_____
☐ convulsions	_____
☐ depression	_____
☐ diabetes	_____
☐ drug problem	_____
☐ heart disease	_____
☐ high blood pressure	_____
☐ overweight	_____
☐ suicide	_____
☐ tuberculosis	_____
☐ any inherited disease	_____

Females Only

51. At what age did your periods begin? _____
52. Do you have any problems with your periods? ☐ Yes ☐ No
53. Do you have irregular periods? ☐ Yes ☐ No
54. Do you have cramps? ☐ Yes ☐ No
55. Do you take medicine for your periods? ☐ Yes ☐ No
56. Do you have breast lumps or discharge from your nipples? ☐ Yes ☐ No
57. Have you ever been pregnant? ☐ Yes ☐ No
58. Have you ever had an abortion? ☐ Yes ☐ No

Males Only

59. Have you had any lumps in your testicles? ☐ Yes ☐ No
60. Have you ever made someone pregnant? ☐ Yes ☐ No

For official use only

Reviewed by: _____ Date: _____

Notice of Privacy Practices
April 7, 2003

Effective Date

Laurel Children's Clinic

NOTICE OF PRIVACY PRACTICES

This Notice Describes How Medical Information About You May Be Used and Disclosed and How you Can Get Access to This Information.
Please Review It Carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of you health information and how we may use and disclose you health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing you medical plan for your medical services.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family member that are directly involved in you care or who assist in taking care of you. We will use and disclose your PROTETED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to organization that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials

in order to protect the President other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institution or law enforcement officials if you are an inmate or under the custody of the law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you, We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The rights to access inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice or our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Title of Privacy Official	Physican
Name of the Privacy Official	Nitin Chopde
Name of the Practice	Laurel Children's Clinic
Address of Practice	13932 Baltimore Avenue, Laurel, MD 20707 831 E. University Blvd, Suite 32, Silver Spring, MD 20903
Phone number of Privacy Official	301-776-9000

For More information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services, Office of Civil Rights
200 Independence Avenue, S.W., Washington, D.C. 20201
877-696-6775 (toll-free)

Laurel Children's Clinic

13976 Baltimore Avenue, Laurel MD, 20707

831 E. University Blvd., Suite #32, Silver Spring, MD, 20903

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

Signature of Parent or Legal Representative **Date**

(If signed by legal representative please specify relationship to patient)

Once Registration Forms are completed you can email them to the office at:

Laurelchildrensclinic1@gmail.com

or

Fax them to:

301-776-9259

or

bring the registration forms the day of the appointment.

PLEASE SEND/BRING A COPY OF INSURANCE CARD ALONG WITH REGISTRATION FORMS

THANK YOU!