13976 Baltimore Avenue, Laurel, MD 301-776-9000
831 University Blvd, Suite 32, Silver Spring, MD 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?	Ĭ Yes No
Pharmacy Telephone No:				Sex:	Ĭ M Ĭ 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

CHILD HEALTH INVENTORY
(Birth - 12 Yrs)
Please Complete Both Sides

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

****Please bring in a record of your child's vaccinations for us to copy.****

Concerns

1. Do you have any particular concerns regarding your child?

_____

_____

_____

Prenatal and Birth History

2. Birth weight _____ height _____
3. Was your baby early? ☐ Yes ☐ No
   Was your baby late? ☐ Yes ☐ No
   If yes to either, how many weeks? _____
4. Was your baby born at home? ☐ Yes ☐ No
5. Mother's age at the time of this pregnancy? _____
6. Number of pregnancies: _____
7. Number of living children: _____
8. Month prenatal care was started: _____

At any time during this pregnancy did you:

9. Have bleeding? ☐ Yes ☐ No
10. Have flu or other infections? ☐ Yes ☐ No
11. Have persistent vomiting? ☐ Yes ☐ No
12. Need drugs other than vitamins or iron? ☐ Yes ☐ No
13. Have high blood pressure? ☐ Yes ☐ No
14. Have other illness or accidents? ☐ Yes ☐ No
15. Were you or your doctor worried about this pregnancy? ☐ Yes ☐ No
16. Did you use alcohol or street drugs during this pregnancy? ☐ Yes ☐ No
17. Were you on WIC? ☐ Yes ☐ No
18. How long was the labor? _____
19. Were there any difficulties with labor? ☐ Yes ☐ No
    If yes, explain: _____

    _____

    _____
20. Please ***circle*** any of the following that happened to your child during the first two weeks after delivery:

jaundice	jittery/shaky
blue spells	longer hospital stay
colic	problems breathing
infections	cried a lot
trouble feeding	mother depressed

21. Has your child had a tuberculosis (TB) skin test? ☐ Yes ☐ No
    If yes, date _____
    a) Is your child foreign-born? ☐ Yes ☐ No
    b) Has your child had close contact with a TB infectious person? ☐ Yes ☐ No

Development

22. At what age did your child:

smile or respond	_____
roll over	_____
sit alone	_____
crawl	_____
take 10 steps alone	_____
join words	_____
potty train—pee	_____
potty train—poop	_____
have her first period	_____

Social

23. Who lives with your child? (name, relationship, age)

_____

_____

_____

24. Do you see your child as different in any way compared to other children his/her age? ☐ Yes ☐ No
    If yes, in what way? _____

    _____
25. Does your child have trouble getting along with teachers in school? ☐ Not in school yet ☐ Yes ☐ No
26. Does your child have trouble learning? ☐ Not in school yet ☐ Yes ☐ No
27. Does your child need extra help in math or reading? ☐ Not in school yet ☐ Yes ☐ No
28. Does your child have trouble getting along with other children? ☐ Yes ☐ No
29. Has your child shown aggressive verbal, physical or sexual behavior? ☐ Yes ☐ No
30. Within the last 12 months, has your child been in a relationship in which there were threats, pushing, grabbing, hitting, kicking, breaking things, or other hurting? ☐ Yes ☐ No
31. ***Circle*** any of the following that describe your child:

won't obey	sucks thumb/fingers
slow to learn	bites nails
jealous	temper tantrums
overactive	holds breath
irritable	nightmares
bad temper	trouble sleeping
speech difficulty	eats dirt or paint
doesn't pay attention	have to spank
happy child	good child

(over)

Nutrition

32. List what your child has had to eat and drink in the past 24 hours: _____

_____

33. List the number of servings your child has of these foods each day:

_____Milk _____ Bread/Pasta/Grains

_____Fruits/Vegetables _____ Meat

34. Mark number of meals your child eats each day:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

35. Is your child a fussy eater? ☐ Yes ☐ No

36. Does your child eat too much? ☐ Yes ☐ No

37. Do you give vitamins or iron? ☐ Yes ☐ No

38. Is/was your child on WIC? ☐ Yes ☐ No

Health History

39. Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, explain and give dates: _____

_____

_____

40. List any health problems/surgeries your child has had:

_____

_____

41. List any medication your child is currently taking, including over-the-counter and herbal medications:

_____

_____

42. List any food/medication your child is allergic to:

_____

_____

43. ***Circle*** any of the following that apply to your child:

allergies
anemia
eyes cross or wander
frequent colds
frequent diarrhea
frequent vomiting
frequent sore throats
heart murmur
joint pain
mouth breather
night time cough
seizures
severe constipation
shortness of breath
snores
trouble hearing
over active
wets bed
wets/dirties pants
ignores parents

Dental

44. Does your child take fluoride drops or tablets or use fluoridated water? ☐ Don't know ☐ Yes ☐ No

45. Do your child's teeth get brushed daily? ☐ Yes ☐ No

46. Are your child's teeth flossed daily? ☐ Yes ☐ No

47. Does your child visit the dentist at least once a year? ☐ Yes ☐ No

Family History

48. ***Circle*** any of the following problems that members of the child's family have had:

alcoholism
allergies
any inherited disease
asthma
blood disease
cancer
child abuse
physical abuse
sexual abuse
convulsions
depression
diabetes
drug abuse
heart disease
heart attack at a young age
high blood pressure
high cholesterol
overweight
suicide
tuberculosis

Safety

49. Does your child use an age-appropriate car seat / seat belt? ☐ Yes ☐ No

Car seats should face rear until 12 months of age. Car seats should be used until children reach 80 pounds. Maryland State law requires the use of booster seats up to age 8. (RCW 46.61.687 and 46.61.688) Experts recommend using a booster seat *at least* until a child is 4'9" tall.

50. Do you have a properly working smoke detector in your home? ☐ Yes ☐ No

51. Do you have Ipecac on hand in case of accidental poisoning? ☐ Yes ☐ No

52. Do you know how to help your child if he/she is choking? ☐ Yes ☐ No

53. If your child is riding a bicycle, does he/she use an approved bicycle helmet to prevent head injury? ☐ Doesn't ride ☐ Yes ☐ No

54. Have you taught your child about personal safety and what to do if someone bothers or attempts to molest him/her? ☐ Yes ☐ No

For official use only

Reviewed by: _____ Date: _____

Notice of Privacy Practices Effective Date
April 7, 2003

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 workersô 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 Childrenôs 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!