Pediatric Cardiology Patient Registration

Patient Information

Child's Name: First Name – M I – Last Name	Nick Name	Birth Date	Sex	AGE
			[] M [] F	

Mother (❒ Birth ❒Stepmother / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Mother?* **Yes / No**

Mother's Full Name (First M. Last)		Profession		Date of Birth
Home Address		City	State	Zip
Mother's Employer Name & Address			Work Phone Number ( )	
Home Phone Number	Cell Phone Number		Mother's Home E-mail	

Father (❒ Birth ❒Stepfather / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Father?* **Yes / No**

Father's Full Name (First M. Last)		Profession		Date of Birth
Home Address		City	State	Zip
Father's Employer Name & Address			Work Phone Number ( )	
Home Phone Number	Cell Phone Number		Father's Home E-mail	

Referring Physician – (Primary Care Physician) Contact Info

Physician Name:	
Reason for Today's Visit:	

Primary Insurance Information

Policy Holder's Name (As it appears on card)			Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name		Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer		Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address		Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )	

Secondary Insurance Information

Policy Holder's Name (As it appears on card)			Social Security Number of Subscriber	
Primary Insurance Company / Health Plan Name		Sex of Policy Holder [] M [] F	Policy Holder Date of Birth	Effective Date
Policy Holder's Employer		Employer Health Plan? [] Yes [] No	Identification/Policy Number	
Insurance Address		Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )	

Pediatric Cardiology – New Patient History Form

New Patient Information- Información del Paciente

Patient Name/Nombre de Pacient: _____
Date of Birth/Fecha de Nacimiento: _____
Primary Care Provider/Doctor Primario:_____
Email:_____

HPI:
Reason for Cardiology evaluation/ Razón por la Evaluación Cardiaca: _____
□ **Murmur** □ **Chest Pain** □ **Palpitations** □ **Dizzy** □ **Syncope** □ **Hypertension** □ **Hypercholesterol**
□ **Family History of Heart Disease** □**Irregular heart beat**

PMH:
Birth Hx/ Historia de nacimiento:
Complications during Pregnancy/ Complicaciones durante el embarazo: □ Yes □ No
If yes, Please explain/Favor explique:_____

Birth Weight/ Peso de Nacimiento:_____ **lbs**/kg (Please circle/circule por favor)
Length of Pregnancy/Longitud de Embarazo: _____**Weeks**/Semanas
Vaginal/C-Section Vaginal/ Cesaria _____**Days in Hospital at birth**/ Dias en Hospital despures de Nadido(a)

Past Medical History: Please use back of sheet if necessary/Historia Medica Pasada:_____
_____
_____

Chronic Medical Conditions/Condiciones Medicas Cronicas:_____
_____
_____

Prior Surgeries/Ha tenido alguna Cirugía(s)? □ Yes □ No **Prior Hospitalizations/**Hospitalizaciones? □ Yes □ No
Explain/Favor explique:
_____

Medications/Medicamentos:_____ **Allergies/Alergias:**_____
_____ _____

Immunizations up to date/Vacunas al corriente? □ Yes □ No

Social /Family History:
Patient lives with/Paciente vive con? **Check all that apply**/Indique todos los que aplique:
□ **Mother**/Madre □ **Father**/Padre □ **Sister/**Hermana (s)_____
□ **Brother**/Hermano (s)_____ □ **Grandparents**/Abuelos □ **Other/** Otro_____

Child attends daycare/Atiende a la guadaria □ Yes □ No
Child attends school/Atiende Escuela: □ Yes □ No **Grade**/ Grado: _____

Participates in sports /deportes? □ Yes □ No _____

Pets in household/Mascotas en la casa? □ Yes □ No **Type of pet**/Cual mascota? _____

Smokers in household/Fumadores en el hogar? □ Yes □ No
□ **Mothe**r/Madre □ **Father**/ Padre □ **Sister/** Hermana □ **Brother**/Hermano
□ **Grandparents**/Abuelos □ **Other**/Otro _____

Patients Name / Nombre de Paciente: _____

Family History

Y	N		Relationship to Patient-Relacion al Paciente
○	○	**Born with Heart Disease** / Nacido con enfermedades del corazón	
○	○	**Sudden death**/Muerte repentina	
○	○	**Arrhythmia**/Arritmia	
○	○	**Cardiomyopathy – dilated**/ Miocardiopatia-Dilatada	
○	○	**Cardiomyopathy – hypertrophic**/Miocardopatia-Hipertrofia	
○	○	**Coronary artery disease**/Enfermedad de Arteria Coronaria	
○	○	**Hypertension**/Alta Presion	
○	○	**Diabetes mellitus**/Diabetes	
○	○	**High Cholesterol**/Alta cholesterol	

Diet/ Dieta:
Newborn:
(please circle) Formula/Formula **Breastmilk/**Pecho _____**Oz per hour**/ Onsas por Hora

Solid Foods/Comida Solidos □ Yes □ No
What is the patient eating/Cual es la comiendo del paciente: _____

General

Y	N	Former	
○	○	○	**Tobacco Use** Uso de Tabaco
○	○	○	**Alcohol Use** Uso de Alcohol
○	○	○	**Drug Use** Uso de Drogas Ilicitas
○	○	○	**Sexual Activity** Actividad Sexual

Review of Systems									
	Y	**N**		**Y**	**N**		**Y**	**N**	
General:	○	○	**Appetite Change** Cambios de apetito	○	○	**Activity Change** Cambios en actividad	○	○	**Irritability** Irritabilidad
	○	○	**Lethargy**/Letargo	○	○	**Trouble Sleeping**/Dificultad para dormir			
Eyes: **Ojos**	○	○	**Blurred Vision** Vision borrosa	○	○	**Corrective Lenses** Usa Lentes			
ENT: **Otto riño**	○	○	**Gum Bleeding** Sangrado de Encias	○	○	**Hearing Loss** Perdida de Audicion	○	○	**Nasal Congestion** Cogestion Nasal
	○	○	**Nosebleeds** Sangrados de Nariz	○	○	**Sleep Apnea** Apnea del sueno	○	○	**Tooth Pain** Dolor de Diente
	○	○	**Teething**/Denticion	○	○	**Sore Throat**/Dolor de Garganta			
Cardio/Vasc:	○	○	**Chest Pain** (Dolor de Pecho	○	○	**Cool Extremeties** Extremidades Frias	○	○	**Color Change** Cambio de color
	○	○	**Easy Fatiguability** Se fatiga facilmente	○	○	**Excessive Sweating** Sudoracion	○	○	**Fainting** Desmayo
	○	○	**Fast Heart Rate** Latido Rapido	○	○	**Irreg. Heart rate** Latido Irregular	○	○	**Murmur** Soplo o Murmullo
	○	○	**Palpitations**/Palpitaciones						
Respiratory: **Repiratorio:**	○	○	**Asthma Symptoms** Sintomas de asma	○	○	**Chronic Cough** Tos cronico	○	○	**Recurrent Wheezing** Silbilancias Constantes
	○	○	**SOB with Exercise** Falta de aliento con ejercisio	○	○	**Snoring** Ronquidos	○	○	**Frequent Pneumonia** Neumonia frequente
GI: **Gastro:**	○	○	**Abdominal Distention** Distencion abdominal	○	○	**Abdominal Pain** Dolor abdominal	○	○	**Eating Problems** Problemas de alimentacion
	○	○	**Reflux**/ Reflujo	○	○	**Nausea**/Nausea	○	○	**Vomiting**/Vomito
GU: **Urologia:**	○	○	**Blood in Urine** Sangre en la Orina	○	○	**Decrease Urination** Orina infrecuente	○	○	**Frequent Urination** Orina Frecuente
MSK:	○	○	**Bone Deformity** Deformidades de hueso	○	○	**Joint Pain** Dolor de coyunturas	○	○	**Joint Swelling** Hinchado
	○	○	**Muscle Aches**/Dolor Muscular				○	○	**Scoliosis**/Escoliosis
Derm/Derma:	○	○	**Birthmarks**/Lunares	○	○	**Cyanosis**/Cianosis	○	○	**Rash**/Sarpullido
	○	○	**Nail Changes**/Cambio en las unas						
Neurological: **Neurologico:**	○	○	**Dizziness** Mareo	○	○	**Headache** Dolor de cabesa	○	○	**Seizures** Convulsiones
	○	○	**Weakness**/Debilidad						
Endo/Meta:	○	○	**Weight Gain** Aumento de Peso	○	○	**Slow Growth** Crecimiento Lento	○	○	**Weight Loss** Perdida de Peso
Hematologic: **Hematologia**	○	○	**Bleeding Problems** Problema de sangrado	○	○	**Easy Bruising** Moretones con facilidad	○	○	**Swollen Glands** Inflamación de las glándulas
Psychiatric	○	○	**ADD**	○	○	**ADHD**	○	○	**Depression**/Depresion
	○	○	**School Problems**/ Problemas academicas						

Signature_____ **Date/Fecha**: _____

Signature of Individual Completing Form (Firma de Persona Llenando Formulario)

Relation to Patient *(Relacion al Paciente):* □ Self (Mismo) □ Parent (Padres) □ Guardian (Guardián)

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize Pediatric Cardiology of Maryland 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 judgment 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 released to the following individuals:

1. _____

2. _____

3. _____

Pediatric Cardiology of Maryland has my permission to leave voicemail messages concerning treatment on my:
(Please check all boxes that apply)

- o Home Voice Mail or Answering Machine
- o Cell phone
- o Work Voice Mail

_____ _____
Print Name of Patient Print Name of Authorized Representative

_____ _____
Patient/Authorized Representative Signature Date

I do **NOT** authorize the release of any verbal information (Other than appointment reminders).

_____ _____
Print Name of Patient Print Name of Authorized Representative

_____ _____
Patient/Authorized Representative Signature Date

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 Cardiology of Maryland Notice of Privacy Practices, 2014 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.

_____

Patient Name (print)

_____

Responsible Party Name (print)

_____ _____

Responsible Party Signature Date

Office Use Only

The following attempts to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices have been made:

Date:_____ Date:_____ Date:_____

Attempt Description:_____

_____

Staff Name:_____

_____

Staff Signature

Financial Policies Acknowledgment

I acknowledge that I have received, or had the opportunity to receive a copy of the Financial Policies of Pediatric Cardiology of Maryland, LLC while in the office, or on the Pediatric Cardiology of Maryland website (www.PediatricCardiologyMD.com). 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.

I have read and understand the financial policies of Pediatric Cardiology of Maryland LLC, and agree to comply and accept the responsibility for any payment that becomes due as outlined in the policy.

Patient Name_____

Responsible Party Name _____Relationship _____ _____

Responsible Party Signature_____ Date_____