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
□ **Mother**/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 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 released 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 Cardiology of Maryland's 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.

_____

Financial Policies Acknowledgement

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. 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 currency copy of the Financial Policies.

_____

Patient Name (Print)

_____ _____

Responsible Party Name (Print) Responsible Party Relation to Patient

_____ _____

Responsible Party Signature Date