Towson Pediatrics
Patient Registration

Patient Name ______________________________ Date of Birth__________
Last First Middle
Address:

____

Sex:_____ Race:______

Phone Number:________________ Residing with:__________________________

Mothers Name:______________________ Employer:________________________

Address:____

Phone Number:_________________ Work Number:_____________________

Fathers Name: _________________ Employer:________________________

Address:____

Phone Number:_________________ Work Number:_____________________

Primary Insurance Carrier:____

Name of Policy Holder:___________________________ Date of Birth______________

Relationship to Patient: ___________________________

Policy Number:___________________________ GroupNumber:___________

Effective Date:____________

Secondary Insurance:____

Emergency Contact:___________________________ Relationship:____________

Phone Number:_________________ Work Number:__________________

****COPY OF FRONT AND BACK OF INSURANCE CARD IS REQUIRED****

Policy Holders Signature:___________________________ Date:__________

MRN:
Patient Name:

(Patient Label)

Date:	
SOCIAL HISTORY	
Place of birth:	Language spoken at home:
Name of Mother:	Occupation:
Name of Father:	Occupation:
Other/Guardian:	Occupation:
Who lives at home?	

FAMILY HISTORY *(please list your immediate family members below)*

Name	Age	Relationship to patient	Health Problems

Are there any blood relatives who have had any of these problems?

☐ Asthma	☐ Birth Defects	☐ Cancer	☐ Diabetes
☐ Drug/alcohol	☐ High blood cholesterol	☐ High blood pressure	☐ Hyperactivity
☐ Mental retardation	☐ Psychiatric illness	☐ Seizures	☐ Sickle cell disease
☐ Tuberculosis			

BIRTH HISTORY

Name and location of hospital:

Problems during pregnancy:

Birth weight: Full term? ☐ Yes ☐ No Type of Delivery: ☐ Vaginal ☐ Cesarean Section

Problems during or immediately after birth:

Went home after: *(number of days)*

DEVELOPMENT

Please write at which age your child first began to:

Sit alone: Walk alone: Use single words: Toilet trained:

Any school problems now or in the past?

Name of present school: Grade level:

MEDICAL HISTORY

Current Medications:

MRN:
Patient Name:

(Patient Label)

MEDICAL HISTORY *(continued)*	
List any major illnesses, operations or hospitalizations below	Date(s)
1.	
2.	
3.	
4.	

ALLERGIES
List any reactions your child has to foods, medications, or insects below

Reviewed by: ______________________________ Date reviewed: __________

Towson Pediatrics

120 Sister Pierre Drive Suite 305

Towson, Md 21204

Office: 410-769-8801 Fax: 410-769-8803

Demographics

Patient Name and Date of Birth:

Patient Race:

Mother Race:

Father Race:

Patient Primary Language:

Secondary Language:

patient Hispanic or Latino:

Email for Patient Portal:

How did you hear about us?

TOWSON PEDIATRICS
Patient Registration

PATIENT AUTHORIZATION FORM

PATIENT NAME:______________________________________

AUTHORIZATION TO RELEASE INFORMATION:

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize the release of medical information pertaining to medical treatment requested by my health insurance carrier or the Health Care Financing Administration and its agencies for determination of benefits coverage.

______________________________ ____________________

Authorized Signature Date

AUTHORIZATION TO PAY INSURANCE BENEFITS:

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize payment directly to the above named physician, or his/ her billing administration. Otherwise payable to me but not to exceed the regular charges for the services provided.

______________________________ ____________________

Authorized Signature Date

Towson Pediatrics

Patient authorization personnel

Patient is allowed to be accompanied by and make medical (decisions Parents)

1. Name:__________________________________

   Relationship:__________________________________

   Phone number:__________________________________

2. Name:__________________________________

   Relationship:__________________________________

   Phone number:__________________________________

3. Name:__________________________________

   Relationship:__________________________________

   Phone number:__________________________________

Parents name:

Parents Signature:

Date:

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*Patients Name:*________________________ *Date of Birth:*______________

Office Policy Agreement

Date:

I have received a copy of the new office policies and agree to all terms and conditions.

*Parents Name (Print):*___________________________

*Signature:*_______________________________