

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: _____

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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
1814 Belair Rd.
Fallston, MD 21047
(O) 443-981-3337 (F) 443-981-3286

Financial Responsibility & Office Policies

Billing

- As part of our contract with the insurance companies, we are required to collect co-pays at the time of the visit. If you are not able to pay the copay, it may be necessary to reschedule the appointment.
- Full payment is due at the time of service for self-pay patients.
- We understand that there may be extenuating circumstances where full payment for balances may not be possible. In these situations, we ask that you contact our office manager to set up monthly payment arrangements. We may require a credit card on file (in our secure patient payment portal) for monthly payment plans.
- If you have an overdue balance, and you have not made financial arrangements, we may need to reschedule your appointment.
- Unresolved, outstanding balances (where financial arrangements have not been made) may result in dismissal from the Practice.
- We accept Visa, Mastercard, American Express and Discover credit cards as well as personal checks.
- Returned checks will be assessed a \$25.00 fee.

Missed appointment charges

We do charge for missed appointments. There is a \$35 fee for a routine prior scheduled, missed or cancelled appointment with less than 24 hours notice. Illness visits should be cancelled more than 4 hours in advance. There is a \$15 fee for missing a vaccine only visit with one of our medical specialists. Late arrivals may need to be rescheduled.

- If you arrive 15 minutes late (or later) for your appointment, we will do our best to accommodate you. However, on certain days, it may be necessary to reschedule your appointment.

Insurance

- We participate with many insurance plans; however, coverage varies widely and part or all of your services may not be covered by your plan. If we participate with your insurance plan, we will submit the claim for you. It is your responsibility to provide accurate and timely insurance information to our Practice. Inaccurate or untimely insurance information may result in denial or non-coverage of services and will become the financial responsibility of the guarantor.
- If we are designated as your primary care physician (PCP), please ensure that our name and phone number appear on your insurance card. If your insurance plan requires a PCP designation, and we

Record Release Fees

- The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing medical information without your written permission. Medical records will be provided to you electronically (through the patient portal) at no cost.
- A fee of \$0.76 per page will be assessed for printed records, up to a maximum of \$22.00 per record.
- Please allow at least 2 weeks to process medical records.

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Patient Name: _____ DOB: _____

Office Policy Agreement

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

Parent Name (print): _____

Parent Signature

Date